UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JOSHUA DUNN, *et al.,*

Plaintiffs,

v.

JEFFERSON DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections; RUTH NAGLICH, in her official capacity as Associate Commissioner of Health Services for the Alabama Department of Corrections; and ALABAMA DEPARTMENT OF CORRECTIONS,

Defendants.

CIVIL ACTION NO.:
2:14-cv00601-MHT-TFM

**EXPERT REPORT OF PROFESSOR CRAIG HANEY, Ph.D., J.D.**

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## I. Expert Qualifications

1. I am a Distinguished Professor of Psychology and the UC Presidential Chair, 2015-2018 at the University of California, Santa Cruz, where I also currently serve as the Director of the Legal Studies Program. My area of academic specialization is in what is generally termed "psychology and law," which is the application of psychological data and principles to legal issues. I teach graduate and undergraduate courses in social psychology, psychology and law, and research methods. I received a bachelor's degree in psychology from the University of Pennsylvania, an M.A. and Ph.D. in Psychology and a J.D. degree from Stanford University, and I have been the recipient of a number of scholarship, fellowship, and other academic awards.

2. I have published numerous scholarly articles and book chapters on topics in law and psychology, including encyclopedia and handbook chapters on the backgrounds and social histories of persons accused of violent crimes, the psychological effects of imprisonment, and the nature and consequences of overcrowded prison conditions as well as solitary or "supermax"-type confinement. In addition to these scholarly articles and book chapters, I have published two sole-authored books: *Death by Design: Capital Punishment as a Social Psychological System* (Oxford

University Press, 2005), and *Reforming Punishment: Psychological Limits to the Pains of Imprisonment* (American Psychological Association Books, 2006), and, along with the other members of a National Academy of Sciences Committee on which I served, I co-authored the committee's report, published in book form as *The Growth of Incarceration in the United States: Exploring the Causes and Consequences*, released in April 2014.

3. In the course of my academic work in psychology and law, I have lectured and given invited addresses throughout the country on the role of social and institutional histories in explaining criminal violence, the psychological effects of living and working in institutional settings (typically maximum security prisons), and the psychological and systemic consequences of extreme prison conditions, particularly overcrowding and solitary confinement. I have given these lectures and addresses at various law schools, bar associations, university campuses, and numerous professional psychology organizations such as the American Psychological Association.

4. I also have served as a consultant to numerous governmental, law enforcement, and legal agencies and organizations, including the Palo Alto Police Department, various California Legislative Select Committees,

the National Science Foundation, the American Association for the Advancement of Science, and the United States Department of Justice. For example, in the summer of 2000, I was invited to attend and participated in a White House Forum on the uses of science and technology to improve crime and prison policy, and in 2001 I participated in a conference jointly sponsored by the United States Department of Health and Human Services (DHHS) concerning government policies and programs that could better address the needs of formerly incarcerated persons as they are reintegrated into their communities. I have continued to work with DHHS on the issue of how best to insure the successful reintegration of prisoners into the communities from which they have come. More recently, I consulted with the Department of Homeland Security on immigrant detention-related issues, and I served as both a consultant to and an expert witness before the United States Congress. I was appointed in 2012 as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. In conjunction with the release of the National Academy committee's report that I mentioned earlier (*The Growth of Incarceration in the United States: Exploring the Causes and Consequences)*, I traveled to Washington, DC several times in 2014 and 2015, to, among other things, brief members of Congress, their

staffs, and the White House on our findings. A copy of my curriculum vitae is attached to this Expert Report as Exhibit 1.

5. My academic interest in the psychological effects of various prison conditions is long-standing and dates back to 1971, when I was still a graduate student. I was one of the principal researchers in what has come to be known as the "Stanford Prison Experiment," in which my colleagues Philip Zimbardo, Curtis Banks, and I randomly assigned normal, psychologically healthy college students to the roles of either "prisoner" or "guard" within a simulated prison environment that we had created in the basement of the Psychology Department at Stanford University. The study has since come to be regarded as a "classic" study in the field of social psychology, demonstrating the power of institutional settings to change and transform the people who enter them.[1]

6. Since then I have been studying the psychological effects of living and working in real (as opposed to simulated) institutional environments, including juvenile facilities, mainline adult prison and jail

[1] For example, see Craig Haney, Curtis Banks & Philip Zimbardo, *Interpersonal Dynamics in a Simulated Prison*, 1 International Journal of Criminology and Penology 69 (1973); Craig Haney & Philip Zimbardo, *The Socialization into Criminality: On Becoming a Prisoner and a Guard*, in Law, Justice, and the Individual in Society: Psychological and Legal Issues (J. Tapp and F. Levine, eds., 1977); and Craig Haney & Philip Zimbardo, *Persistent Dispositionalism in Interactionist Clothing: Fundamental Attribution Error in Explaining Prison Abuse*, Personality and Social Psychology Bulletin, 35, 807-814 (2009).

settings, specialized correctional housing units (such as solitary and "supermax"-type confinement), and problematic prisons and prison systems (especially those with overcrowded conditions of confinement). Because I focus primarily on the psychological and "mental health" effects of correctional environments, I have studied the ways that mentally ill prisoners, especially, are affected by their conditions of confinement and how prison systems address the needs of this vulnerable population. In the course of that work, I have toured and inspected numerous maximum security state prisons and related facilities (in Alabama, Arkansas, Arizona, California, Florida, Georgia, Idaho, Louisiana, Massachusetts, Montana, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah, and Washington), many maximum security federal prisons (including the Administrative Maximum or "ADX" facility in Florence, Colorado), as well as prisons in Canada, Cuba, England, Hungary, Mexico, and Russia. I also have conducted numerous interviews with correctional officials, guards, and prisoners to assess the psychological impact of penal confinement, and statistically analyzed aggregate data from numerous correctional documents and official records to examine the effects of specific conditions of confinement on the mental health and well-

being of prisoners confined within them and on the quality of prison life in general.[2]

7. I have been qualified and have testified as an expert in various federal courts, including United States District Courts in Arkansas, California, Georgia, Hawaii, New Mexico, Pennsylvania, South Carolina, Texas, and Washington, and in numerous state courts, including courts in Colorado, Florida, Montana, New Jersey, New Mexico, Ohio, Oregon, Tennessee, Utah, and Wyoming as well as, in California, the Superior Courts of Alameda, Calaveras, Kern, Los Angeles, Marin, Mariposa, Monterey, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz, Shasta, Tulare, Ventura, and Yolo counties. My research, writing, and testimony have been cited by state courts, including

[2] For example, Craig Haney & Philip Zimbardo, *The Socialization into Criminality: On Becoming a Prisoner and a Guard*, in Law, Justice, and the Individual in Society: Psychological and Legal Issues (pp. 198-223) (J. Tapp and F. Levine, eds.) (1977); Craig Haney, *Infamous Punishment: The Psychological Effects of Isolation*, 8 National Prison Project Journal 3 (1993); Craig Haney, *Psychology and Prison Pain: Confronting the Coming Crisis in Eighth Amendment Law*, Psychology, Public Policy, and Law, 3, 499-588 (1997); Craig Haney, *The Consequences of Prison Life: Notes on the New Psychology of Prison Effects*, Psychology and Law: Bridging the Gap (D. Canter & R. Zukauskiene, eds.) (pp. 143-165), Burlington, VT: Ashgate Publishing (2008); Craig Haney, *On Mitigation as Counter-Narrative: A Case Study of the Hidden Context of Prison Violence*, University of Missouri-Kansas City Law Review, 77, 911-946 (2009); Craig Haney, *Counting Casualties in the War on Prisoners*, 43 University of San Francisco Law Review 87-138 (2008); Craig Haney, *The Perversions of Prison: On the Origins of Hypermasculinity and Sexual Violence in Confinement*, American Criminal Law Review, 48, 121-141 (2011) [Reprinted in: S. Ferguson (Ed.), Readings in Race, Ethnicity, Gender and Class. Sage Publications (2012)]; and Craig Haney, *Prison Effects in the Age of Mass Imprisonment*, The Prison Journal, 92, 1-24 (2012).

the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court.[3] A statement of compensation and a list of the cases that I have testified in as an expert at trial or by deposition during the last four years are attached to this Expert Report as Exhibit 2.

8. I have been retained by Plaintiffs to evaluate and offer my opinion regarding the provision of mental health care to prisoners in the Alabama Department of Corrections (ADOC), including the various ways in which mentally ill prisoners are being adversely affected by certain conditions of confinement to which they are exposed. In particular, I have focused on the adverse effects of overcrowding and understaffing on prisoners' mental health care and critically evaluated the ADOC's Segregation practices and their harmful effects on prisoners' mental health.

## II. Basis of Expert Opinion

10. In the course of evaluating and forming opinions about these issues, I utilized the methodology that I typically employ to evaluate conditions of confinement and policies and practices in a correctional facility or prison system. Based on my experience conducting such

[3] For example, see *Brown v. Plata*, 131 S.Ct. 1910 (2011).

evaluations over the last forty years, my methodology is consistent with the methodology used by other mental health and corrections experts.

11. Thus, as part of this methodology, I have reviewed and relied on a wide range of documents provided by counsel for Plaintiffs. A list of the documents that I have been provided and that I reviewed as the basis for the opinions I express herein is attached to this Report as Exhibit 3. In addition to those documents, I conducted a number of onsite tours and inspections at various ADOC facilities (described throughout this Report, with further details provided in the Appendix, attached to this Report as Exhibit 4), in the course of which I conducted in-passing interviews with ADOC and MHM staff members, as well as an extensive number of both cell-front and individual, confidential interviews with prisoners at each facility I toured. Also, time permitting during my site visits to different correctional facilities, I typically reviewed a sample of the official ADOC files and records that pertained to (at least) some of the prisoners whom I interviewed.

12. I toured, inspected, and conducted interviews at the Julia Tutwiler Prison for Women, on September, 14 and 15, 2015; Holman Correctional Facility on September 16, 2015; Easterling Correctional Facility on March 14, 2016; Bullock Correctional Facility on March 15 and

16, 2016; Bibb County Correctional Facility on March 17, 2016; Kilby Correctional Facility on March 18, 2016; Donaldson Correctional Facility on March 21 and 22, 2016; and St. Clair Correctional Facility on March 23, 2016. I returned to conduct interviews at Holman Correctional Facility on June 1, 2016; Donaldson Correctional Facility on June 2, 2016; and St. Clair Correctional Facility on June 3, 2016.

13. I also should note that, although I had a wealth of information on which to rely and base my opinion—certainly enough information to reach and support the conclusions that are stated in the remainder of this Report—my fact-finding was limited in some unprecedented respects (including being limited to closely-timed cell-front interviews of no more than three minutes, being prevented from conversing even cell-front with prisoners in certain units in certain facilities, being prevented from even seeing certain units, and having access to prisoner files only during the relatively brief time that they could be reviewed on-site). It is also my understanding that, remarkably, a substantial number of documents are still being, or have just recently been, produced by Defendants. Obviously, I have not had an opportunity to completely review or incorporate these newly recently produced documents into my analysis. Thus, although I have more than enough information on which to base my conclusions, my work

on this matter is ongoing and I reserve the right to supplement my opinion if new information becomes available.

## III. Summary of Expert Opinion

14. Based on my tours and inspections, interviews, and document reviews, I have concluded that the Alabama prison system is in a state of crisis. This crisis has been created by a combination of chronic and severe overcrowding and very significant understaffing. Alabama is perennially the nation's most overcrowded prison system, and its chronic overcrowding continues to take a terrible toll on the state's prison inmates, especially those who are mentally ill. The two deep-seated and inter-related problems of overcrowding and understaffing are exacerbated by (and, in turn, further contribute to) the use of physically deteriorated and psychologically dangerous conditions of confinement. This toxic combination has produced a systemic breakdown that manifests itself in, among other things, woefully inadequate mental health care for prisoners, the overreliance on punitive isolation in an attempt to maintain control over prisoners and stabilize an inherently unstable system, and the housing of many severely mentally ill prisoners in unfit conditions of isolated confinement (ones that are, frankly, not only unfit for them but, in some instances, for anyone).

15. These problems are extreme, pervasive, and deep-seated. The

suffering among the prisoners is palpable and clearly visible. It was corroborated virtually without exception by all of the prisoners with whom I spoke. Prisoner after prisoner—many of them severely mentally ill—told harrowing tales of exposure to dangerous conditions, systemic mistreatment, and the chronic neglect of their fundamental psychiatric needs as well as a crass disregard for their basic human dignity. The challenge in each of the days that I spent evaluating the facilities that I toured and completing the interviews that I conducted was not one of finding evidence of these problems but rather adequately and fully documenting the extraordinary number of these problems that I repeatedly encountered. If the extreme and systemic nature of these problems was clear to me in just over two weeks (15 days) spent touring and interviewing prisoners in the Alabama system, ADOC officials clearly knew about the chronic deficiencies and neglect of prisoners' basic needs that pervades the Alabama prison system. The only possible way that ADOC officials could be "unaware" of these systemic abuses taking place would be by knowingly looking away from what was happening before them each day.

A. *Dangerous Conditions and Lack of Control*

16. Individual facilities in the ADOC appear to veer from "merely" dysfunctional and chronically dangerous to, frequently, acutely out-of-

control. Living under such conditions is painful and damaging to any prisoner in ADOC custody, but especially for the mentally ill, who are more vulnerable and at much greater risk of significant harm.

17. At the first men's facility I visited (Holman), the Segregation Unit, which houses many prisoners with mental health problems (see Ex. 4, Holman), was so out-of-control that I was told that, "for security reasons," I could not even speak briefly at cell-front with any of the prisoners housed there. I was also told that I could not tour the third tier of the unit because the staff could not ensure my safety. The scene inside that unit, which I will describe in more detail below, resembled nothing so much as bedlam, and was unlike anything I have seen in many, many years of doing such work.

18. The system was, if anything, even more out-of-control when I returned in March 2016. During just one week-and-a-half of inspections, of the six institutions I was supposed to tour and inspect, I was unable to enter one of them at all (Holman), and could not see significant parts of two others (Bibb, St. Clair) because the prisons were experiencing riots or prisoner uprisings of some sort. Specifically, when I returned to Holman, intending to complete my earlier tour, I was not allowed into the living area of the prison at all because a riot was underway the Monday morning I arrived (and had been in progress in some form since the previous Friday).

19. I was unable to tour fully one-half of a second facility (Bibb) later in the week because another riot or "major disturbance" was underway, or had just been quelled, in one of the housing units. The warden stated explicitly that he "did not want to put you [us] in harm's way" by bringing us inside that half of the prison, which he admitted was still unsafe. But the half of that prison I was able to inspect was hardly "under control." While there I witnessed one of the people from the housing unit where the disturbance had occurred attempt to escape from an outside holding pen where he and several other prisoners from that unit were being held; he climbed over the fence and was running across the yard until he was chased down by several correctional officers and forcibly escorted back to the holding pen. Also, during the time I was touring the Infirmary at the same facility, Bibb, a prisoner in a "suicide watch" or "observation" cell used a blanket to cover the window of the cell and was in the process of attempting to commit suicide by using a long piece of string or cord that he had somehow obtained and wrapped around his neck.

20. During the day that I was at Donaldson, I was told that the tour and interviews that were to be conducted the next day at St. Clair were possibly in jeopardy because violence had broken out there as well. By the end of the day at Donaldson, a compromise had been reached: I was

allowed to tour St. Clair but only for two hours, during which time I was prohibited from talking to any prisoners. Further, I was not allowed to actually enter any mainline housing units (but was restricted to viewing them from the officers' station). In fact, all prisoners were locked in their cells before I came to the units at St. Clair and, except for segregation (where I was not allowed to go to the second tier of the two tier units or to talk to any prisoners, even at their cell fronts, during the tours), I viewed the units from afar—from the stairwell leading down to them—and was prohibited from even looking into any cells. This meant also we were unable to photograph any of the general population cells (because no one, including the lawyer in our group who was taking pictures, was permitted on the housing unit floors or anywhere near the front of the cells or the prisoners). This also made it impossible to meaningfully select any general population prisoners to interview (since I was prohibited from even a three-minute cell-front conversation or observation, and therefore knew absolutely nothing about any one of them).

21. Even individual prisons and prison systems that are highly dysfunctional and very poorly run are generally able to do the one thing that prisons are inherently designed to do and that correctional staff are taught to accomplish above all else—maintain order. Yet the ADOC appears

unable to manage even this. I do not believe that, in some 40 years of studying prisons (including very problematic ones), I have ever been denied entry to a prison or been unable to complete an inspection because the prison could not ensure my safety (and, by implication, the safety of everyone else inside). I do not believe this has happened a single time, let alone in three out of six prisons I was scheduled to visit within a single eight-day period.

B. *Overcrowding and the Effect on Prisoners with Mental Health Needs*

21. The significant overcrowding and understaffing that plagues the ADOC has resulted in the use of dangerously crowded dormitory housing that not only risks the physical safety but also places the mental health of Alabama prisoners in grave risk. (The dormitory housing configuration in use in certain Alabama prisons, where very high security prisoners are mixed in with older, infirm or psychiatrically unstable, and otherwise vulnerable prisoners is unprecedented, in my experience, and in any event is especially dangerous and unworkable.) Overcrowded prison conditions typically have direct adverse effects on all prisoners, increasing tensions, conflicts and the likelihood that disciplinary infractions will result in segregated confinement. This dynamic is especially problematic for mentally ill prisoners, who are often much more sensitive and reactive to

harsh and stressful overcrowded conditions, therefore more likely to commit disciplinary infractions (related to their mental illness), and more likely to end up in segregated housing which is, in turn, especially traumatic and destructive to their well being.

22. Overcrowding and understaffing also have adverse indirect effects on prisoners by virtue of the way they change the "behavior" of prisons at a systemic level. That is, they increase the likelihood that there will be systemic breakdowns in the way that individual prisons and the overall prison system are able to function. For example, overcrowded prison systems have fewer available beds for appropriate classification assignments (i.e., the ability to determine and send prisoners to the "right" place, including making sure that vulnerable mentally ill prisoners are housed in facilities where they are safe and have access to appropriate levels of care), and they have fewer effective rehabilitative programs in which prisoners can engage (thus failing to lower the likelihood of recidivism). This translates into increased levels of dangerous and dysfunctional idleness (i.e., prisoners in overcrowded prisons have less meaningful activity of any kind in which to engage). The ADOC appears to suffer from all of these overcrowding- and understaffing-related problems.

While these problems affect all prisoners, ADOC's mentally ill prisoners are placed at grave risk as a result.

23. In addition, overcrowded prison systems are typically unable to address the needs of their physically and psychiatrically vulnerable population because they lack adequate medical and mental health resources. In the ADOC, this lack of adequate mental health resources (i.e., staff, space, treatment, and programming) has led to an almost total breakdown in the delivery of mental health services necessary to address the significant needs of mentally ill prisoners (as addressed more thoroughly below). Even the so-called treatment units in the ADOC (the Residential Treatment Units or "RTUs" at Bullock, Donaldson, and Tutwiler, and the Stabilization Units or "SUs" at Bullock and Tutwiler) do not function as such. Many of the prisoners in these units are very seriously mentally ill, with long and very serious trauma histories, oftentimes prior mental hospitalizations, and multiple instances of suicidality. Yet these prisoners receive no more than the barest minimum of individual and group therapy (if they receive any at all), limited to a few minutes a week and, for some, even less than that. As described more thoroughly below, it is not remotely enough treatment to address the complicated needs of this vulnerable population.

*C. Overuse of Segregation, Especially for the Mentally Ill*

24. Although the facilities I toured differed in age and level of disrepair, they varied very little in the extent to which prisoners housed in them are suffering and their mental health needs are being ignored. Prisoners in many of these units live in almost unimaginable squalor. The segregated housing units I saw—all of them—were dehumanizing and degrading, and subject prisoners not only to extreme forms of isolation but to severe deprivations in almost every conceivable way. Several of the units were among the worst I have ever seen. The units at Bibb County Correctional Facility are dangerous to the physical as well as mental health of the prisoners and in my opinion should be closed immediately. Several of the other segregation units, for example at Holman, Kilby (including what is referred to as "Big Seg" there), and St. Clair are terrible and intolerable. Unfortunately, they house a large numbers of prisoners, including large numbers who are seriously mentally ill, all of whom are placed at significant risk of serious psychological harm.

25. Segregation units at St. Clair are truly horrific. The prisoners in these units are reduced to a despairing, rudimentary existence, barely functioning, and just "holding on" amidst deplorable and oppressive conditions. I also encountered something there that I would not have

believed if it had not been confirmed by numerous persons with whom I spoke: prisoners being left outside, overnight, for days at a time, standing and sleeping in an open concrete "walk" area that is otherwise used for outdoor exercise. This was done apparently because the prison had "run out" of segregation cells, so prisoners were consigned to sleep in the prison yard. This is a dangerous and degrading practice for anyone, but especially likely to cause further deterioration among mentally ill prisoners.

26. The terrible condition of the ADOC segregation units bears directly on the plight of mentally ill prisoners in the system because so many of them are housed in these units. They languish in segregation, with little or no meaningful mental health contact or access to activities of any kind, and are placed at significant risk of very serious psychological harm because of the especially harsh conditions and extreme isolation to which they are subjected. The ADOC's policy of placing so many very seriously mentally ill prisoners in these units is dangerous and indefensible. The degraded state of ADOC's segregation units also raises the very real possibility that prisoners who are not already suffering from identifiable mental illness before being placed in one of these extremely harsh units will develop such problems during or after their segregated confinement.

27. In fact, the reliance on harsh mechanisms of institutional control, especially the overuse of segregation or solitary confinement, is characteristic of chronically overcrowded and understaffed prison systems. These systems turn to severe forms of punishment in an attempt to manage their overly large prison population, especially because they lack the resources to meet prisoners' basic needs or control their behavior in more positive ways (such as through meaningful programming). Lacking "carrots," they turn disproportionately to "sticks." However, such an approach ignores the long-term negative consequences of resorting to these excessively punitive approaches. The ADOC has fallen into precisely this dysfunctional pattern.

28. Among other things, this pattern has resulted in large number of mentally ill prisoners cycling back and forth between the two most painful and problematic extremes of penal confinement—overcrowding and isolation—both of which pose especially grave risks to their well-being. These prisoners, in particular, are suffering, and their long-term mental health has been placed in jeopardy. For some of them, their deterioration, decompensation, and even more serious consequences (in the form of self harm and suicide) may prove irreversible.

D. *Inadequate Mental Health Treatment*

29. It is clear that chronic, uncontrolled overcrowding, overuse of segregation, and a series of pre-existing, unresolved problems in the ADOC have led to systemic breakdowns in several crucial areas. Virtually without exception, every prisoner I spoke to on the mental health caseload (MH1s and above)—many of whom had lengthy and very serious psychiatric histories—complained about receiving no more than, at best, superficial and sporadic contact with mental health staff. Very seriously mentally ill prisoners, including those with prior freeworld and in-prison mental hospitalizations and documented instances of self-harm and suicidality, are seen (let alone treated) infrequently by mental health staff, have little (or more often, no) access to meaningful treatment or therapy of any kind, and are barely being monitored in the truly abysmal and dangerous living conditions where they are housed.

30. There does not appear to be systematic or appropriate levels of mental health care being regularly delivered to very seriously mentally ill prisoners anywhere in the system. There certainly was not adequate treatment at the facilities I toured, and based on my interviews of prisoners who had spent time in various facilities, deposition testimony provided by mental health staff, and review of ADOC documents, there is no evidence

that mental health treatment is any different, much less better, at any of the other facilities.

31. For example, the RTU at Bullock consists of several large dormitories where very seriously mentally ill prisoners are housed. The prisoners I spoke to were not receiving careful mental health monitoring or treatment. Instead, although the unit is run as a somewhat more benign housing unit than others I saw, the very vulnerable and seriously mentally ill prisoners confined there have little or no access to meaningful treatment programs.

32. *Inadequate Group Counseling or Activities:* The treatment area that adjoins the housing unit in the Bullock RTU is relatively large and provides adequate space for a number of possible therapeutic activities. Yet it appears to be woefully underutilized. Prisoners said very few "classes" were being offered; the day I toured, there was a "class list" up on the wall that listed all of the "groups" that supposedly were being offered—unfortunately, the schedule was for 2015 (not 2016)!

33. At Donaldson, the separate units in the RTU are barely distinguishable from the harsh Segregation Units. In some instances, they appeared to have nearly the same architectural design, with the same oppressive atmosphere created inside (so that a person entering one versus

another would be hard pressed to tell which was which—i.e., a "treatment" versus a "punishment" unit).

34. *Inadequate Individual Counseling:* At Donaldson, like at Bullock, there was little evidence of any kind of meaningful treatment program underway, and little or no space in which to conduct it. Indeed, when the brief and infrequent mental health contacts do occur, they take place in the hallways outside the housing units and, because they are closely monitored by custody staff, who stand nearby, are non-confidential.

35. *Inadequate Mental Health Monitoring:* There is inadequate monitoring of mentally ill prisoners throughout the system, especially (but not limited to) the Segregation Units. Seriously mentally ill prisoners go for long periods (sometimes permanently) without any meaningful mental health contact whatsoever, and the contact that does take place is often limited to brief cell-front "drive-bys" or "check-ins" that are cursory in nature, non-confidential (thus unlikely to surface sensitive information), and scarcely constitute mental health "treatment" by any definition. The treatment plans are superficial, often times boilerplate prescriptions that are only occasionally changed, and one boilerplate is substituted for another. In any event, the system does not have the capacity—in personnel or space—to even begin implementing these treatment plans.

36. *Inadequate Individual Counseling:* Prisoner after prisoner reported that when the infrequent mental health contacts with their counselors actually did occur, they lasted for no more than a few minutes. Thus, very seriously mentally ill prisoners—some of whom have been under psychiatric care since childhood, who have experienced multiple mental hospitalizations, and who have engaged in multiple acts of suicidality and self-harm—are receiving no more than a few minutes of mental health contact a month (and some report less than that).

37. *Inadequate Psychiatric Monitoring:* The brief psychiatric consultations that occur every 90 days, and that sometimes take place over television monitors (so-called "telepsychiatry"), are typically limited to very brief discussions of an inmate patient's psychotropic medications, and nothing more.

E. *A System in Crisis*

38. As I will discuss in a separate section at the end of this Report, the problems I have identified and the patterns discussed are truly systemic in nature. As I have already noted and will mention several times in the course of the analysis that follows, there was a remarkable amount of consistency in the data on which I relied—consistency in the observations that I made from facility to facility and consistency in what prisoner after

prisoner told me, both about the damaging conditions of confinement to which they are exposed and the egregious treatment, or lack thereof, that they receive. Many of the prisoners I interviewed had been housed in other ADOC facilities (in some instances, many such facilities) and they confirmed that these problems are widespread, pervading the entire system. Moreover, the prisoners' observations were corroborated by the aggregate system-wide data that I have examined, as well the deposition testimony of ADOC and MHM officials with oversight responsibilities that encompass the entire system. Thus, the facilities about which I comment in detail in the following pages are by no means "outliers;" they are clearly the rule and not the exception in an overall extremely dysfunctional and problematic system.

39. Finally, there is evidence that these very serious systemic problems are getting worse rather than better. Many prisoners told me that, at some point in the not-too-distant past, apparently in the immediate aftermath of the Bradley settlement,[4] things had improved somewhat in the ADOC, especially with respect to the provision of mental health services.

[4] In *Bradley v. Haley*, Case Number 92-CV-70-N, a class of severely mentally ill male prisoners challenged the provision of inadequate mental health care in Alabama prisons. The case settled in 2000, with an agreement to provide increased mental health staffing, a new residential treatment unit for mentally ill prisoners, and other increased therapeutic and psychiatric services and treatment.

However, these improvements soon eroded and have continued to steadily decline, reaching the current crisis level that now characterizes the system. Thus, the ADOC appears to be moving decidedly in the wrong direction, with no signs that the widespread problems that I will identify and discuss in the following pages have been grasped by the ADOC Commissioner and other ADOC leadership or are in the process of being alleviated.

**IV. Facility Tours, Inspections, and Interviews**

40. Over the course of a several month period, I toured, inspected, and conducted interviews at a number of ADOC facilities. Although I was permitted to conduct in-passing interviews with ADOC and MHM staff members—many of whom were helpful and informative—who accompanied us on the tours or who we encountered as we moved through the facilities, the bulk of my interviews were conducted with ADOC prisoners. I questioned the prisoners about their conditions of confinement, their mental health status, the problems that they faced within the ADOC, and the practices and procedures each person was subjected to at various facilities (especially their contact with mental health staff and the extent of their mental health programming or treatment). I spoke to many prisoners cell-front (in brief, and time-limited interactions in the housing units that I passed through), and conducted typically longer, confidential interviews in

different office spaces made available in the different facilities. The prisoners whom I selected for confidential interviews were sometimes selected randomly from the prisoner roster at the various facilities, sometimes were persons whom I had first interviewed cell-front, and sometimes were selected in advance by counsel for Plaintiffs. I concentrated on (although I did not exclusively limit myself to) interviewing those prisoners who were on the mental health caseload in the ADOC and/or those who were housed in the various Segregation Units in the facilities I toured.

A. *Julia Tutwiler Prison for Women*

41. On September 14, 2015, I toured and inspected Julia Tutwiler Prison for Women, in Wetumpka, Alabama, and conducted cell-front interviews with a number of prisoners housed in the units that I toured. I returned the next day, September 15th, and conducted individual, confidential interviews with a pre-selected group of prisoners (some picked randomly from the prison roster, some picked during the tour that I conducted the day before). Tutwiler is a maximum security or "close custody" facility (housing all security levels of women prisoners, including women sentenced to death) that, on the days I was there, held approximately 940 prisoners, including 248 in the Annex. In addition to a

mainline or general population unit, it has 19 Segregation beds (in L Unit), as well as five "seg overflow" beds located in the Infirmary, an RTU (H Unit) with 33 open-bay beds (16 of which were filled), and a Stabilization Unit with eight cells (five of which were filled the days I was there).[5]

42. Like many other facilities, mental health care at Tutwiler is severely inadequate. The women at Tutwiler each told a similar story of receiving only infrequent mental health contact—despite being on the mental health caseload and taking psychotropic medications. They reported being seen no more than once a month, for a brief, pro forma visit. Counselors change so often that building trust—a crucial factor for effective counseling—is difficult if not impossible to attain.

43. The Segregation Unit at Tutwiler is small unit, holding 16 women on the day I was there; many of them were double-celled. A number of the women in this unit with whom I spoke cell-front were on the mental health caseload and they voiced similar complaints about their treatment.

44. Those complaints included having requests for assistance go unanswered; a number of them said that the only way to be seen by mental health was to actually commit self-harm or declare a "crisis," and that even

[5] For Tutwiler and all other facilities, population figures were estimated from several sources, including information that was provided by prison officials on the day we visited, the ADOC monthly reports, and inmate rosters provided in the course of our tours.

that is not always sufficient. I heard one story of a woman, Ms. S.R.L., who "everybody knew . . . needed help." Although she was "begging for mental health care," her pleas went unanswered. Eventually, she made a serious suicide attempt that required hospitalization. Her story, and the many others that I heard, reflect and exemplify the system-wide issues that pervade Tutwiler and characterize the ADOC more generally: the severe mishandling of suicidal prisoners and prisoners with serious mental health problems, the overuse of segregation (especially for mentally ill prisoners), and grossly inadequate mental health care.

45. The stories I was provided with in interviews I conducted with prisoners at Tutwiler, including that of Ms. S.R.L., are described in more detail in the Appendix (Ex. 4, Tutwiler).

B. *Holman Correctional Facility*

46. On September 16, 2015, I toured and inspected Holman Correctional Facility, outside Atmore, Alabama. Holman is a maximum security or "close custody" prison (that also houses some minimum security prisoners as well as death-sentenced prisoners). According to the ADOC monthly report, as of the end of September, 2015, Holman housed 978 prisoners (including 162 housed on death row). In addition to a mainline or general population unit, Holman has a separate, large Segregation Unit

comprised of three separate tiers. They are: K Unit (63 total beds, housing 58 prisoners on the day that I visited); L Unit (68 total beds, housing 66 prisoners on the day that I visited); and M Unit (with 67 total beds, housing 65 prisoners on the day that I visited).

47. The Segregation Unit was the first area that I toured at Holman. I was completely unprepared for what I found. The air inside the three-tier unit was thick with the smell of burning paper or some other material as I entered. Prisoners were loudly screaming "help me" or holding up pieces of paper that read "help" or other pleas (e.g., "look at my medical file," "no showers"). Other prisoners were banging hard on their cell doors and yelling so loudly that it was difficult to hear the person standing alongside me. A number of the windows on the doors were completely covered, so it was impossible to see inside, and a number of doors were blackened on the outside and appeared to have been burned from fires; the safety glass on several of the windows on the cells had been shattered. There was what appeared to be urine puddled on the floor in front of several cells. The correctional captain and counsel for defendants admonished me at the outset of the tour that, "for security reasons," I was not allowed to approach any of the cells, even for a brief cell-front interview, or to communicate in any way with the prisoners. This meant that I could not engage with any of

the prisoners who were shouting and imploring me to help them or listen to their complaints. I also was told that I would not be allowed to tour the third floor of the three-tier unit at all because, even with my escorts, the captain explained, they could not ensure my safety. Thus, I was unable to directly see anything that might be taking place in this presumably even more dangerous area of the prison. When I asked to look inside what appeared to be an open cell on the first tier of the unit—one with yellow tape across the door (which I mistakenly thought might mean that the cell was under repair and therefore unoccupied)—I was told abruptly and without explanation that I could not go near it. I learned later that a prisoner had committed suicide in the cell just a few days earlier and that the yellow tape marked it as a potential crime scene.

48. I also toured the Death Row unit at Holman, which is adjacent to the Segregation Unit and houses 162 condemned prisoners. The Death Row Unit is arranged and run much like a standard Segregation Unit. At the near end of the first tier I entered, I saw several cells that I was told were used as "Suicide Watch" or "Crisis Cells," for prisoners in states of severe psychiatric crisis and at risk of self harm. Other than administrative convenience (i.e., the lack of any other more appropriate spaces at the

prison), the logic of housing suicidal prisoners in a unit populated by condemned prisoners escapes me. The practice is extremely problematic.

49. Overall, the Holman Segregation Unit was a shocking scene. In my 40 years of doing such work, I am not sure I had ever seen one quite like it. Although my tour of the unit was relatively brief—I could not speak or communicate with any of the prisoners housed there—I, frankly, needed a short break to collect myself before continuing.

50. I went from the Segregation Unit to tour several of the general population dormitories at Holman. The dormitory housing units at Holman are very unusual in that they house a number of maximum security or "close custody" prisoners. I do not know of any other prison system that places a significant number of maximum-security prisoners in open dormitories. The reason that this is a disfavored practice is perhaps obvious: dormitory housing is difficult for many prisoners, often precipitates conflict, not only affords little or no privacy but also little or no protection or safety, especially at night when staff coverage tends to be thin. The D Dorm I entered appeared to be completely full, and all of the men housed there appeared to be present in the unit and sitting around their bunks, not engaged in any real activity. Pervasive inactivity or idleness is

problematic for prisoners in general, but especially for the mentally ill (who have special needs for meaningful activities in which to engage).

51. I also randomly pre-selected (from the prison roster cross-referenced for those both on the mental health caseload and housed in the Segregation Unit and some who I encountered during my tour) ten or so prisoners with whom to conduct individual, confidential interviews. Of the list of the ten or so prisoners I selected, I was told that only two were willing to be interviewed and that all of the others had "refused." I was also told that one prisoner, Mr. X.B., who was not only on my list but also coincidentally was someone whom I saw in his cell during my tour of the Administrative Segregation Unit—he appeared at the time to be especially distressed but gesturing at his cell door and seemingly eager to talk with me—was unavailable.[6]

52. I returned to Holman Correctional Facility on March 14, 2016, with the understanding that I would be able to complete my tour of the Segregation Unit—specifically, the upper third tier that I had been prohibited from touring earlier. I also was scheduled to conduct brief cell-front interviews with prisoners in the Segregation Unit (which, as I noted earlier, I also had been prohibited from doing during my September 2015

[6] I later learned that this may not have been true. See Appendix, Ex. 4 Bullock.

tour), as well as to conduct confidential interviews with several pre-selected prisoners (whom I was unable to interview on my earlier visit). However, shortly after we entered the prison and began to be escorted to the Segregation Unit by the Warden and several other staff members, a correctional officer hurriedly approached the Warden and informed him that a riot had broken out in a housing unit where similar events had taken place a few days earlier.

53. We were rushed out of the interior of the prison and, as we congregated near the Warden's office, were told that we would not be allowed to re-enter the prison. We negotiated an alternative plan with counsel for the Defendants. However, I was never given an opportunity to complete my tour of the Segregation Unit, or to conduct brief cell-front interviews with anyone housed inside it.

54. I returned to Holman on June 1, 2016, to conduct individual, confidential interviews with several prisoners from the Segregation Unit whom I had asked to interview on my earlier visit, on September 16, 2015 (when I was told that they and others were unwilling to speak with me). I was given a very limited amount of time in which to conduct these interviews; for whatever reason, there were long delays in bringing the

prisoners whom I had selected to the interview room. Nonetheless, I conducted interviews with two prisoners from my original list.

55. My three visits to Holman led me to conclude that this facility, like every other ADOC facility, severely mishandles prisoners with serious mental health problems and provides grossly inadequate mental health care. In particular, prisoners in Segregation, including those on the mental health caseload, are frequently ignored, even when they inform officers and counselors that they feel suicidal. The indifference to mentally ill prisoners is so severe that prisoners resort to setting fires to get attention. One man told me the story of an prisoner who had asked for assistance "again and again" but never received comprehensive mental health treatment. After he committed suicide (just a few days before my September 2015 tour), his body was not discovered until the next day because ADOC did not conduct security checks that night.

56. The troubling information that I obtained from the interviews that I conducted with prisoners at this facility is described in more detail in the Appendix (Ex. 4, Holman).

C. *Easterling Correctional Facility*

57. On March 14, 2016, after my abbreviated visit to Holman, I traveled to Clio, Alabama, where I toured and inspected Easterling

Correctional Facility. Easterling is a medium-security facility that, according to ADOC monthly reports, as of the end of March 2016, held 1515 prisoners. In addition to a mainline or general population unit, it has a separate Segregation Unit (Unit B), which contains 102 beds and, as of March 11, 2016, held 77 prisoners. Because my time was short—it was afternoon by the time we arrived at Easterling—I concentrated only on the facility's Segregation Unit. I also conducted individual, confidential interviews with three prisoners whom I pre-selected from the group of prisoners who were in the Segregation Unit and also on the mental health caseload.

58. Easterling Correctional Facility is newer than Holman, and became operational in 1990 (per the ADOC website). It is comprised of single-story buildings, including the Segregation Unit that I toured. The Segregation Unit has two sides to it, each lined with cells that have closed solid doors; there were two Suicide Watch cells at the end of one of them. The unit was quiet at the time I entered it. All or most of the prisoners in this unit appeared to be double-celled. The cells are small and cramped, and prisoners complained of poor ventilation inside. One of the Suicide Watch cells was occupied—it was completely dark, with a man lying on a mattress on the floor of the cell. The second Watch cell was empty and I

was allowed to enter it. It was filthy and did not appear suicide proof—there was a rusted metal bed on the floor and protrusions in the cell that could be used to fasten a sheet or other ligature.

59. There was evidence at Easterling that, like the other facilities that I visited, it provides inadequate mental health treatment and overuses Segregation to house mentally ill prisoners. In particular, mentally ill prisoners are placed in Segregation and then largely ignored by mental health and custodial staff. To the extent any mental health treatment is provided, it consists of largely unmonitored psychotropic medication prescriptions and minimal counseling that amounts to no more than "walk-throughs" lasting for no more than a few minutes.

60. The experiences relayed to me by prisoners with whom I spoke at Easterling are described in more detail in the Appendix (Ex. 4, Easterling).

D. *Bullock Correctional Facility*

61. On March 15, 2016, I traveled to Bullock Correctional Facility, near Union Springs, Alabama, to tour and inspect the facility, to conduct brief cell-front interviews with prisoners in the course of my tour, as well as to meet separately for several individual, confidential interviews with several prisoners (including some housed in Segregation). I also had an

opportunity to review the medical/mental health files of several of the prisoners I had interviewed or was scheduled to interview at the facility. I returned the next day, March 16, 2016, to continue touring and interviewing prisoners, including conducting individual, confidential interviews with several prisoners, most of whom I pre-selected from my tours, and some prisoners who were recommended by counsel for Plaintiffs.

62. Bullock is a medium-security facility that, according to the ADOC monthly report, as of the end of March 2016, held 1585 prisoners. The main building opened in 1987 (per the ADOC website). In addition to a mainline or general population unit, the main building contains a Segregation Unit (which has 30 beds, all of which were filled as of March 11, 2016). The main building at Bullock has several specialized units, including a Crime Bill Dorm, Safe Dorm, and the Substance Abuse Program dorm. A separate mental health building contains an RTU with 282 beds, and housed 260 prisoners as of March 11, 2016. The RTU also includes a Stabilization Unit, which houses 30 prisoners, although part of the unit is sometimes, if not always, used as Segregation.

63. Although I toured and inspected essentially the entire facility, the brief interviews that I conducted in the housing units and my longer,

confidential interviews were concentrated primarily among those prisoners who were housed in the Segregation and specialized mental health units (the RTU and SU).

64. Bullock appears to have been built in the same era as Easterling (circa mid-1980s), and has a number of distinct, differently purposed housing units. The first area that I toured, B Unit (in the main building), is a small, hallway-like lockup (Segregation) unit, with cells that have solid doors and small exterior windows. It had the dank odor and atmosphere of a very confined segregation unit where prisoners are rarely allowed out of their cells and have begun to deteriorate as a result. Although the cells were difficult to see into, they appeared grim—sparse with very little property but nonetheless disheveled. I noticed a number of mattresses laid out in the hallway. I was later informed that this was a form of punishment—being denied access to their mattresses during the day—for prisoners who were doing disciplinary segregation time.

65. We also toured a number of other mainline housing units in the prison, for the most part just entering them to observe briefly, including the "faith" or honor dorm, a substance abuse program dorm, and some general population dorms. We also entered the chapel at the prison, which was a beautifully kept, tranquil area, in notable contrast to the rest of the prison.

Before leaving the main building, we traveled to the Infirmary to observe the procedures for dispensing medications.

66. During my tour, I visited the separate building that houses the RTU at Bullock, which serves as the main medium-security in-patient treatment unit for men in ADOC custody, often referred to as "the Blue Building." The housing units are smaller than the others in the prison, and consist of nine separate units, including five that are "open RTU" or dormitory housing units (three of which hold approximately 50 prisoners, and two smaller ones which hold 10 prisoners each), a "Stabilization Unit" or "SU" (that holds about 30 prisoners), and a Segregation Unit. The open units were very quiet the day we were there, with little or no activity taking place in them. At 11 AM, I counted a third or more of the prisoners lying in their bunks, many with covers pulled up over their heads.[7]

67. We toured the area between the RTU and the SU/Segregation Unit that serves as a treatment space for the facility's mental health program. The area was clean and well-lit, with a number of potential

[7] This pattern—inmates lying in bed, with covers pulled over their heads, even as late as midday, is seen in the most severe and dysfunctional lockup units, where prisoners have little or no purposeful activity in which to engage. Prisoners in these kinds of units often lose track of time, fail to maintain a semblance of any meaningful (albeit self-imposed) program or schedule, and "give in" to the emptiness of the isolation to which they are subjected. It is especially problematic for mentally ill prisoners, whose contact with the social reality around them is already likely to be fragile and compromised.

treatment areas and/or classrooms that appeared entirely serviceable. Unfortunately, although the area is appropriate for group and other forms of counseling, it is grossly underutilized. During the confidential interviews that I conducted (described in depth in the Appendix, Ex. 4, Bullock), prisoner after prisoner complained about the lack of group activity. Their complaints were corroborated by a weekly calendar of group activity posted in the unit—it was a schedule for February 2015, approximately a year before the date of my tour.

68. On opposite sides of the area, there are two cell-like rooms with very large windows that are, therefore, highly visible in the treatment area. The captain leading the tour first said that these were "time-out" cells, and were used only for very short-term confinement, for prisoners who "needed a break." However, I soon found Mr. X.L.I., who had been in this short-term "time out" cell for, by his estimate, five weeks. He said that during that entire time he had been given no programming (for mental health or anything else), no out-of-cell time (except for showers), and not even access to a telephone. My subsequent interview with Mr. X.L.I. is described in depth in the Appendix (Ex. 4, Bullock).

69. The mental health Stabilization Unit at the other end of the treatment area is virtually identical to segregation units I have seen at many

other prisons. The unit was desolate and despairing, and appeared to be filled with very seriously mentally ill prisoners. I saw no evidence that any significant of out-of-cell time was (or could be) taking place there. The interior of the cells had hardly any property in them and they were dirty and unkempt, suggesting that prisoners were languishing in these cells rather than being "stabilized." The prisoners who I met from the unit, whose interviews are detailed in the Appendix (Ex. 4, Bullock) described conditions and treatment that amounted to little more than standard, harmful "lockup," rather than treatment.

70. Despite supposedly being a dedicated mental health treatment facility, Bullock exemplified the same problems that I observed throughout the ADOC: a systemic failure to provide adequate mental health care, both in the main facility and in the RTU; the overuse of Segregation, particularly for prisoners with mental health problems; and correctional officers who ignored or even exacerbated the mental health conditions of the prisoner/patients under their supervision by taunting, threatening, or punishing prisoners who asked for mental health treatment. The failure to provide remotely adequate mental health treatment at the Bullock RTU is particularly alarming. As one of the treatment hubs within ADOC, the fact that Bullock's RTU can provide no more than "walk-through" counseling

sessions that last no more than a few minutes underscores the deep-seated and systemic nature of the ADOC's inability or unwillingness to provide adequate mental health care.

71. The conditions of the Segregation Units at Bullock (in both the main facility and the RTU) are also extremely problematic. Many prisoners, including some who suffer from serious mental illness, are left in grim and oppressive isolation cells virtually around the clock, with breaks for only five or ten minute showers. In the RTU, the so-called Stabilization Unit is little more than a standard Segregation Unit. Rather than providing treatment for the most acutely mentally ill, these units only serve to exacerbate their mental health problems and place them at risk of grave harm.

72. The problematic conditions and practices I encountered at Bullock, and the effects on the prisoners subjected to them, are described further in the Appendix (Ex. 4, Bullock).

E. *Bibb County Correctional Facility*

73. On March 17, 2016, I traveled to Bibb County Correctional Facility, located in Brent, Alabama. I toured and inspected one-half of the facility, conducted brief cell-front and housing unit interviews with a number of prisoners, and individual, confidential interviews with several

prisoners who I selected in the course of my tour. I also had an opportunity to review the medical/mental health files of several of the prisoners I had interviewed or was scheduled to interview at the facility. I was prohibited from touring or conducting cell-front or housing unit interviews with prisoners in approximately one-half of the prison (including the area where the Behavior Modification Unit is located) because, I was told, there had been a "riot" there earlier in the day. Bibb is a medium-security facility that according to Bibb officials, had 1946 beds and housed 1880 prisoners on the day we were there. In addition to a mainline or general population unit, it has a "Behavioral Modification Unit" and a Segregation Unit with 36 beds housing 32 prisoners (on the day I was there).

74. As I mentioned above, on the morning that we arrived at Bibb, we were immediately informed that a riot or "major disturbance" was underway, or had just been quelled, in one of the housing units. The warden stated explicitly that he "did not want to put [us] in harm's way" by bringing our group inside that half of the prison, which he admitted was unsafe. That meant that my tour and brief cell-front and dormitory interviews were restricted to just one half of the facility. (Unfortunately, the Behavior Modification Unit was on the side of the prison that I was unable to tour; I learned later that this unit was the site of the unrest that had

apparently led the Warden to prohibit us from touring that side of the prison).

75. Early in our tour, I witnessed, from a distance, officers lining prisoners up outside the B Dorm (the Behavior Modification Unit), putting them in handcuffs, and yelling at and pushing some of them. This occurred in the apparent aftermath of whatever had gone on earlier that day.

76. I later witnessed one of the people from B Dorm, where the disturbance had taken place, attempting to escape from an outside holding pen where he and several other prisoners were being held; he climbed over the fence and was running across the yard until he was chased down by several correctional officers and forcibly escorted back to the holding pen.

77. I visited the Infirmary, where there were several men in Suicide Watch cells and a sizable group of others inside a large caged-in holding pen, presumably waiting to be seen for treatment. One of the prisoners in a holding cell, B.E.C., told me that he had come from B Dorm and that the officers there "are trying to kill us." As I was speaking to him, one of the lawyers in our group noticed that the man in the adjoining cell, T.B., had placed a blanket over the window to the Watch Cell. Apparently he had a string or ligature of some sort that he had put around his neck and was

preparing to use it. A contingent of correctional officers were summoned and a sergeant resolved the situation with Mr. T.B. peaceably.

78. Each dorm at Bibb has three open housing dorms and a small Segregation Unit or lockup located around a long corridor, physically removed from the rest of the dorm (as well as from any regular staff contact or visible oversight). During my tour, I entered the Segregation area in F Dorm and immediately smelled burning paper or some other material, which the warden explained was the aftereffect of a fire in the small unit. A second Segregation Unit, identical to the first, had the same smell of burning paper in the air, and a similarly filthy floor.

79. The Bibb Segregation Units are difficult to describe and unlike any I have ever seen in decades of doing this work. Each one has only a few cells, and even though there is a bright overhead light, the units typically remain dark. The floors outside the cells are filthy, with charring on both the floor and outside doors of the cells). The cells are very dark inside (requiring the use of a flash to photograph them). The showers that I viewed adjoining two Segregation units were also filthy and deteriorated, and the light switch inside one did not work at all.

80. I toured multiple large open dormitories in the facility, including in F Dorm. In one dormitory, prisoners pointed me to the one

working toilet in the unit (out of four) that accommodated about 120 men. Others said that mental health staff never really came into their unit or monitored their mental health, not even for the large number in the unit with mental health problems.

81. Bibb exemplifies the out-of-control nature of the ADOC. In my one day there, I witnessed evidence of an uprising by prisoners, an attempted escape, a suicide attempt, evidence of recent fires in the Segregation Units, presumably started by prisoners, and the representation by the Warden that one half of the prison was so unsafe that I could not enter it. Any of these incidents would be noteworthy and indicative of a lack of institutional control. Together they reflect the kind of chaos and disorder that appears to pervade the ADOC.

82. My observations and interviews at Bibb also reinforced my observations about mental health care throughout the ADOC: mental care itself is inadequate, Segregation is overused, the conditions themselves are extremely harsh, and the Segregation Units are wholly inappropriate for the mentally ill prisoners confined in them.

83. The conditions and practices that I encountered at Bibb, and their effects on the prisoners subjected to them, as described in the

interviews I conducted there, are described further in the Appendix (Ex. 4, Bibb).

F. *Kilby Correctional Facility*

84. On March 18, 2016, I toured and inspected Kilby Correctional Institution, located in Mt. Meigs, Alabama. In addition to touring and inspecting the facility, I conducted brief cell-front and housing unit interviews with prisoners in the course of my tour, as well as several individual, confidential interviews with prisoners from the Segregation Unit. I also had an opportunity to review the medical/mental health files of several of the prisoners I had interviewed or was scheduled to interview at the facility.

85. In addition to being the intake or receiving facility for all of the men coming into the Alabama Department of Corrections, Kilby is a maximum security or "close custody" facility that, according to the ADOC monthly reports, holds 1288 prisoners overall. The intake or receiving unit at the facility (Unit J) can hold up to 234 prisoners (and held 148 the day we were there). In addition to its mainline or general population and receiving units, it has several Segregation Units, that have, in total, a capacity of 111 (and held 79 on the day I was there).

86. As we entered Kilby, one of our staff escorts indicated in passing that the prison was significantly understaffed; apparently there are currently about 120 correctional officers working at the prison, but they have over 50 vacant positions. [In fact, according to the ADOC Monthly Statistical Report for March 2016, Kilby filled only 156 out of 230, or 67.8%, of its authorized correctional security staff positions and 133 out of 203, or 65.5%, of correctional officer positions.] We entered several of the dormitories where prisoners assigned to Kilby are housed (as opposed to intake, where prisoners stay temporarily). We also toured one of the intake units, J Dorm, which was relatively quiet at the time we entered. Men were sitting on their bunks and there was no movement in the unit—the Warden explained, "we are locked down because of the tour." I did brief interviews with several prisoners who had recently arrived at the prison who explained the intake process as best they could.

87. During my visit to Kilby, I toured multiple segregation or isolation units. O Dorm, which the Warden described as a "single-cell" dorm, is actually Segregation. The unit has about a dozen cells with solid outer doors; the first few of the cells on the right, as you enter the unit, are used as Suicide Watch or Crisis Cells. All of the cells are barren and grim, and all of the prisoners I talked to complained about the conditions.

88. We subsequently toured another set of isolation cells that apparently function as a kind of "administrative segregation" unit for special cases or to house prisoners under investigation for disciplinary infractions. The cells are arranged in a small unit inside the Infirmary and have a "boxcar" design—with an extra solid door (that was open).

89. We visited two other Segregation Units. The first was a smaller unit consisting of a single corridor with twelve cells. They, too, were boxcar-type cells, with the outer doors open. The second, the so-called "Big Seg" or main Segregation Unit at Kilby, is 25 cells long, on each of two sides, and is two stories high. There was a fair amount of noise and cross talk in the "Big Seg" unit, and the smell of something burning. The unit is old and deteriorated.

90. As we moved from one area of Kilby to another, we passed an office that was labeled "Mental Health." There was a small group of men sitting inside, in a waiting area, presumably waiting to see a mental health staff member. It seemed like an ideal opportunity to do brief interviews with a few of them—the kind I had been doing in the housing units in various facilities. I expected that these interviews could be useful since the prisoners obviously were either on the mental health caseload, or had mental health concerns of some sort. They therefore might prove to be good

candidates to interview later, confidentially, to better understand mental health issues at the facility. To my great surprise, counsel for Defendants refused to allow me to speak with them, and we moved on.

91. Kilby Correctional Facility is the institution through which every male prisoner in Alabama enters and is processed into the ADOC (except those who have been sentenced to death). It suffers from the same serious problems that pervade the entire ADOC system: severe mishandling of prisoners with serious mental health problems, including those who are suicidal; inappropriate and dangerous use of segregation; inhumane conditions of confinement; callous and cruel behavior by ADOC staff; and grossly inadequate mental health care with regard to quality, frequency and duration. At Kilby, as in many other ADOC facilities, severely mentally ill prisoners are frequently left to languish in segregation and are ignored by staff–even when they resort to desperate outbursts or report auditory or visual hallucinations.

92. The information I gained from interviews that I conducted with prisoners at Kilby about the conditions and practices that I encountered there are discussed in more detail in the Appendix (Ex. 4, Kilby).

G. *Donaldson Correctional Facility*

93. On March 21, 2016, I traveled to Bessemer, Alabama to tour and inspect Donaldson Correctional Facility (originally named West Jefferson Correctional Facility), conduct brief cell-front and housing unit interviews with prisoners in the course of my tour, and conduct several individual, confidential interviews with prisoners from the Segregation Unit. I also had an opportunity to review the medical/mental health files of several of the prisoners I had interviewed or was scheduled to interview at the facility. I returned the next day, March 22, 2016, to complete these activities. Donaldson is a maximum security or "close custody" facility that, according to the ADOC monthly report, housed 1456 prisoners as of the end of March 2016. In addition to its mainline or general population unit, it has a Segregation Unit that houses 224 prisoners, and an RTU that houses 96 prisoners.

94. I also returned to Donaldson Correctional Facility on June 2, 2016, to conduct individual, confidential interviews with several prisoners pre-selected from the group of prisoners who were in the Segregation Unit and on the mental health caseload, as well as a prisoner whom I originally attempted to interview at Holman Correctional Institution in September 2015, but had been told did not want to speak with me.

95. Donaldson is a large correctional facility, constructed in the early 1980s. Although the brick exterior of the facility is impressive and well-kept, the interior—including the mental health treatment units—is not.

96. The mental health treatment units—Donaldson's "RTU" or Residential Treatment Units—are configured separately, "R-S-T-U" units, in what are intended as graduating levels openness (with S as the most restrictive, and R and U as the most "open"). We entered S Unit or Block first. It appeared indistinguishable from the extremely harsh Segregation Units I had seen at other ADOC facilities. The captain who was escorting us explained to me that "these are closed RTUs, not really Ad Seg, just the most severely mentally ill." (However, it appeared that many, if not most, of the cell doors had green cards on them indicating "Administrative Segregation.") As we walked the tiers in this unit, at 10:30 AM, I noticed that the overwhelming number of prisoners in their cells were lying on their bunks with the covers pulled over their heads.[8]

97. The shower stalls at both levels of the unit had an exposed opening in the wall and a horrible-looking substance or material protruding

[8] Again, as I noted earlier, this is often a sign of pervasive inactivity and idleness of the sort that can overtake prisoners in isolated confinement. The loss of a sense of purpose and the ability to create a structure or program, even though you are confined in your cell almost continuously is very problematic and sometimes termed "the downward spiral" or "fog" of segregation. It is especially problematic for mentally ill prisoners.

out. The prisoners were forced to use this opening as a place to store their bars of soap, despite its unsanitary appearance, and several bars of soap had fallen inside where, understandably, prisoners had chosen not to retrieve them.

98. We entered T block, also a "closed RTU" but apparently "less restrictive," where I was told prisoners were allowed out of their cells for some group activities. However, it, too, looked and felt very much like a standard, very harsh ADOC Segregation Unit. There was a television set out on the open tier, but no prisoners were out of their cells. Here, too, there were green "Ad Seg" cards on nearly all of the cell doors. Only two men on the entire bottom tier of the unit appeared to be awake and, on the second tier, I could find only one, until a second prisoner got up and came to the door. In the U Dorm, one of the "open" RTU units, there were in fact a few people out of their cells and walking around on the unit floor.

99. We also visited the Disciplinary Segregation Units—P and Q—which are relatively small isolation units. The air inside was heavy and dank, the shower was leaking, and empty food trays were left stacked on the unit floor. I was told I was only allowed to do cell-front interviews with prisoners on the first, but not the second, tiers of the unit, for apparently safety-related reasons.

100. On our way to the other side of the prison, we toured one of the open general population dorms (in the non-RTU part of the facility). The open dorms at Donaldson have an unusually configured two-man square arrangement with wooden partitions between them, all arranged as single (rather than double) bunks. There appeared to be about 100 or so bunks in the unit and, although crowded, did not seem quite as congested as some of the other open dormitories in other ADOC facilities I saw.

101. On the other side of the prison, we toured additional Segregation Units, J and I, that are configured the same as the earlier ones I toured (P and Q). Other, larger Segregation Units on that side—E, F, G, and H—are configured like the RTU. A number of the cell doors in the E unit had windows covered, and it was impossible to look into them. Of the ones I could see into, most of the men were sleeping with their covers pulled over their heads. We also toured an even larger Segregation Unit—W—which the captain informed me was a converted cellblock.

102. I also visited the Donaldson Infirmary, where I spoke to Mr. N.L.S., who told me he was confined to a "Z" cell, a version of Infirmary Segregation, where he said he had been kept since December 2014 because of a medical problem and the fact that he has a catheter. He said he had not

been outside for over a year and a half. Other than showers, he said, he just stays in his cell and sleeps.

103. Here, too, the problems I encountered at Donaldson mirror those that I observed across the entire ADOC system. Like many other facilities, prisoners at Donaldson suffer from inadequate mental health care—even the prisoners in the supposed "treatment units" hardly ever receive counseling, and when they do it typically lasts for at most a few minutes. Moreover, for most prisoners in the RTU, counseling is not conducted confidentially—in addition to the cell-front "drive-bys" that are so common throughout the ADOC (and do not provide sufficient confidentiality for prisoners to be candid about mental health issues and problems), the RTU prisoner/patients have their infrequent and brief "counseling" sessions in hallways outside the living units, with correctional officers standing close by and clearly within earshot. Similar to other facilities, Donaldson relies far too heavily on isolation as a substitute for treatment. This means that severely mentally ill prisoners are left alone in their cells, without opportunities for social interaction or meaningful activity, and sit (or lie) sedentary for weeks or months at a time.

104. The information that I obtained from interviews that I conducted with Donaldson prisoners is described in more detail in the Appendix (Ex. 4, Donaldson).

H. *St. Clair Correctional Facility*

105. On March 23, 2016, I traveled to St. Clair Correctional Facility, located in Springville, Alabama, to tour and inspect the facility, conduct several individual, confidential interviews with prisoners from the mainline housing unit at the prison as well as several from the Segregation Unit (randomly selected from a group of prisoners who were on the prisoner roster, or because I had encountered them or, more accurately, their cells, in the course of my tour earlier in the day), and to review the medical/mental health files of several of the prisoners I had interviewed or was scheduled to interview at the facility. St. Clair is a maximum security or "close custody" facility that, according to the ADOC monthly report held 1220 prisoners as of the end of March 2016. In addition to a mainline or general population unit, St. Clair has a Segregation Unit that houses 216 prisoners, and also a "Therapeutic Community" or substance abuse treatment dorm.

106. I also returned to St. Clair on June 3, 2016, to conduct individual, confidential interviews with several prisoners pre-selected from

the group of prisoners who were in the Segregation Unit and on the mental health caseload, as well as a prisoner whom I originally attempted to interview at Holman Correctional Institution in September, 2015, but had been told did not want to speak with me.

107. On the March 23 tour, we visited the Infirmary area at St. Clair. There are five Suicide Watch cells in the Infirmary hallway. According to the card on the door, one prisoner in a Watch cell had been there for five months (date of admission: 10-21-15). Another prisoner, Mr. X.M.B., was in a completely dark room, labeled "Mental Health," lying on the floor. He appeared to have been housed there at least overnight. The card on the door said "hallway." The captain who was escorting us explained that the prisoner was being kept in the "Mental Health office" because that was where mental health staff was going to talk to him. There was no furniture in the room, just a mattress and Mr. X.M.B. lying on the floor. Another prisoner in a Watch Cell, Mr. L.J.Q., had an admission date of 1-22-16, some two months earlier. He confirmed this and said that he was there "waiting for mental health treatment." This cell, too, lacked a bunk and contained only a toilet. I confirmed with the sergeant in the unit that, in fact, the "date of admission" on the cell doors indicated the date at which

the prisoners were placed in Watch Cell, so Mr. X.M.B. had, in fact, been living in his barren Watch Cell for two months.

108. We also toured the Segregation Units at St. Clair, which are comprised of three separate, smallish two-story buildings, containing five units in total (A-E units). The design of the units is unusual, with the first floor recessed below ground level (so that the small windows on the first floor are near ground-level). There is a mental health office space in one of the buildings; no staff members were there when we entered, but there was a receptionist sitting behind the desk near the entrance. We moved from a brief tour of the mental health office space to one of the Segregation Units. Three prisoners in a fenced-in outdoor area approached us along the walkway into the unit and said that they had been kept outside, in this exercise pen, for three days straight. The associate warden directing the tour would not allow a picture to be taken of the men or the area where they were being kept, and terminated my conversation with them.

109. The Segregation Unit I entered first was abysmal. It was dirty and deteriorated, with paint peeling off the walls. The men in the cells immediately began yelling for "help," some screaming, "I've been back here for a year." One of the prisoners yelled that he had urine all over his floor from a backed up toilet. We moved to the other side of the unit, where the

floor was cleaner but the overall scene equally shocking, including men yelling that they had not gotten showers and a host of other complaints. Mr. D.S. told me as I passed by his cell-front that "there's bad stuff going on here—we don't get out, get showers, nothing." A prisoner in another cell, Mr. X.S., was in a completely dark cell, with a covering over most of his door window.

110. We moved from briefly touring these two units, back past the concrete yard where the three men from earlier were still standing, into the B/C Segregation Units, which were virtually identical the previous ones and similarly abysmal, except that the unit was a little more quiet than the first. I entered cell C12, whose occupant, Mr. E.L.C., was elsewhere during my inspection. The cell was unbelievably dirty and disheveled, so extreme that it suggested to me that Mr. E.L.C. may be on the verge of losing complete control of himself and his daily routine. Standing inside the cell, it was almost unimaginable that someone could live there for even a day, let alone for months, which was apparently the case (the date of admission for the prisoner, E.L.C., was 11-3-15, some four months before the date of my inspection).

111. We walked from this unit to the next, but were met with some resistance as I tried to enter Segregation Unit E—the officer said he did not

want to allow me to enter until they had "cleaned it up"—I could see from the landing that there was food on the floor, as well as food trays and glass in front of one of the cells. Pandemonium broke out as we entered, with men shouting, "I haven't had anything for weeks, no soap, no nothing." The man in the cell with the broken window (Mr. Q.A.B.)—which he had apparently just shattered by literally smashing his fist through the security glass—was animated and screaming about rats and snakes in the cells. He said, as I looked inside his disheveled cell, that he was kept outside all night, during which time the officers took all of his property. I entered the other side (Unit D), where correctional officers had just finished cleaning the floor of debris—there was less yelling but basically the same configuration and much the same atmosphere. The cells were dirty and deteriorated inside. The captain escorting us through these units confirmed that the Segregation Units at St. Clair are basically all the same, and that mentally ill prisoners are dispersed throughout them.

112. We also toured some of the general population units, including the honor and faith-based dorms. We had been told in advance that, apparently because of unrest of some sort at the prison, I would be prohibited from conducting even brief cell-front interviews with any of the prisoners. Additionally, we were told that the mainline population was

locked down for the visit and that I would not be allowed to go down on the unit floors, or even look into any of the cells. (This meant that my observations and the photographs we took were limited to views from the landings or walkways at the entrance of each of these units.) From what I could tell from this limited vantage point, the general population units were unremarkable cellblocks, double-celled units with open dayroom areas where apparently prisoners are allowed to congregate. Since the facility was "locked down," I was unable to observe any of this activity actually taking place.

113. St. Clair, like other ADOC facilities, was truly appalling in many respects. I heard loud cries for help in many of the units I entered, prisoners described incessant, uncontrolled screaming, mass violence, fires, breaking glass, and living in total darkness (often due to ADOC's failure to replace light bulbs). I saw prisoners living in barren "Suicide Watch Cells" who had been kept there for months on end, and a prisoner residing in complete darkness, lying on an office floor in a room labeled "Mental Health" and urinating in a plastic bucket. Prisoners were subjected to these dangerous, degrading, and abysmal conditions without any apparent regard for their mental health status or the risk of harm created. Indeed, the seriously mentally ill prisoners I encountered in these units were placed at

very significant risk of serious psychological harm by virtue of the treatment to which the ADOC subjects them to at this facility.

114. Finally, as I noted, one of the most bizarre and alarming things that I heard (and indirectly saw) at St. Clair was that prisoners with Segregation terms were often left outside, in the yard, handcuffed and shackled, overnight for days on end. Needless to say, this practice is unheard of because it is obviously so dangerous and inhumane—dangerous and inhumane for anyone, and certainly for persons suffering from serious mental illness.

115. The information that I obtained from the interviews I conducted at St. Clair, including the discussion of "outdoor Segregation," is described in detail in the Appendix (Ex. 4, St. Clair).

I. *Summary Observations and Analysis*

116. The deficiencies that I observed and have described in the overall conditions of confinement, correctional practices, and mental health care in the ADOC are so glaring, widespread, and extreme that it is difficult to know how to comprehensively summarize them. The abject living conditions that I saw, the accounts that I heard from the scores of prisoners I interviewed (*see* Appendix, Ex. 4) about extremely dangerous environments in which they are housed, the desperation and suffering they

endure, and the absence of meaningful mental health treatment of any kind (except for the administration of psychotropic medications) were remarkably consistent, varying very little if at all from facility to facility, and were profoundly troubling.

117. Moreover, the problems are deep-seated and systemic. Indeed, numerous prisoners not only corroborated each other's accounts in the various facilities in which they were housed, but also repeatedly emphasized that these exact same deficiencies characterized the other facilities in which they had been housed elsewhere in the ADOC. The deprived and degrading conditions, dangerous practices, and nearly non-existent mental health treatment described in the preceding paragraphs were very clearly the rule, not the exception. Because these problems are deep-seated and systemic, they are not caused by isolated instances of individual incompetence and cannot be remedied merely by good intentions or modest changes in personnel. Broad-based, systemic change will be required to address them. Moreover, these problems appear to have plagued the ADOC for many years and, by all accounts, are getting worse rather than better. Thus there is much urgency to addressing them decisively and soon.

118. The deplorable conditions of confinement that exist in the Alabama prison system adversely affect the mental health of all of its prisoners, especially the mentally ill. ADOC is filled with crowded dormitory housing units, a number of which dangerously place maximum security prisoners in close contact—under otherwise very unsafe conditions—with very vulnerable prisoners (including those who are mentally ill). In addition, many of the Segregation Units contain cells that border on being uninhabitable, except that many scores of prisoners are living—existing—in them, including, again, many who are mentally ill.

119. It would be a misnomer to suggest that there is any functioning system of mental health care delivery (beyond medications) operating in any of the ADOC facilities that I toured and where I conducted interviews. Severely mentally ill prisoners—many of whom have long histories of serious psychiatric problems (including mental hospitalizations) in the freeworld, multiple suicide attempts before and during their time in prison, and who have been prescribed powerful psychotropic medications—are being housed in filthy, unkempt Segregation cells where they are deprived of meaningful human contact and activity, and where they languish virtually around-the-clock for days, months, or years. Others—in the most acute and extreme states of psychiatric crisis—end up being housed in

administrative offices or library rooms that lack a bunk or toilet because the prison lacks sufficient numbers of Suicide Watch or Observation cells.

120. The combination of squalor, deprivation, and neglect is, in my experience, simply unprecedented, and not the way prisons are operated anywhere else in the United States.

## V. The Adverse Psychological Effects of Overcrowding on Prisons and Prison Systems

121. I have attributed many of the problems described in this Report to what I have called "overcrowding," and the often concomitant issue of "under-staffing." In this section of the Report I discuss the impact of overcrowding in more detail, and summarize what is known in the psychological literature about its pernicious effects. Overcrowding impacts every aspect of prison life in ways that directly and adversely affect prisoners and correctional officers and undermines the functioning of the prisons in which they live and work. When overcrowding is chronic and severe, as it is in the ADOC, it can precipitate reactions and adaptations that, in turn, exacerbate its harm, leading to systemic dysfunction and even more serious consequences. Exposure to chronic and severe overcrowding

has especially harmful effects on mentally ill and other vulnerable prisoners.[9]

A. *The Nature of Overcrowding*

122. "Overcrowding" means more than merely housing more prisoners than the rated capacity of a particular facility; it also includes the extent to which a prison, or prison system, houses more prisoners than it has adequate resources and infrastructure to provide services for and to humanely accommodate. Even prison systems that increase their rated capacity but do so without commensurate increases in programming, medical, and mental health resources (including space and personnel) can still be "overcrowded," even though, technically, they may not house greater numbers of prisoners than their official design capacity. Thus, a correctional facility "could be operating at fewer prisoners than its rated capacity, yet be overcrowded."[10]

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[9] I have written about these issues at greater length in: Craig Haney, *The Wages of Prison Overcrowding: Harmful Psychological Consequences and Dysfunctional Correctional Reactions*, Washington University Journal of Law & Policy, *22*, 265-293 (2006) [Reprinted in: N. Berlatsky, *Opposing Viewpoints: America's Prisons*. Florence, KY. Cengage Learning, 2010.]; and Craig Haney, *Prison Overcrowding*, APA Handbook of Forensic Psychology (B. Cutler & P. Zapf, eds.) (pp. 415-436), Washington, DC: APA Books (2015). The discussion in this section of my Report draws on those earlier publications and the references cited therein.

[10] R. Ruddell & G. Mays, *Rural Jails: Problematic Prisoners, Overcrowded Cells, and Case-Strapped Counties*, 35 Journal of Criminal Justice 251-260, 255 (2007).

123. Alabama's prisons are chronically and severely overcrowded both in the sense that they house far more people than they were designed to hold, and because they do not have remotely enough programming, medical, and mental health resources—staff, space, and other infrastructure—to humanely house the numbers of prisoners who are confined in them or to remotely address the very significant needs of the large prisoner population.

124. It is also important to note that the negative consequences of overcrowding go beyond the failure to provide essential services to prisoners. Overcrowded prisons are dangerous for staff and prisoners alike because they create a variety of security-related problems and risks. Of course, these security-related problems and risks, in turn, create enormous and often insurmountable obstacles to effective treatment and constitutionally mandated care for mentally ill prisoners.[11]

125. The risks and dangers of overcrowding are well-documented. Corrections officials and prison experts have understood and acknowledged them for decades. There was a time when I first began to study the

[11] I am aware that another Plaintiffs' expert, former Washington state Secretary of Corrections Eldon Vail, is addressing the security-related issues and problems in the ADOC in more depth and detail, so I will not belabor them here, except to acknowledge that they, too, have a negative impact on the mental health of prisoners and impede the effective delivery of mental health care.

psychology of imprisonment in the 1970s, when it was widely accepted in corrections circles that whenever prisons approached 90-95% of their capacity, they were becoming dangerously overcrowded. This was because of the recognition that in order to safely maintain a closed environment like a prison—where people with a variety of problems are closely and involuntarily housed—staff and administrators must have sufficient options to readily move and separate prisoners, both for security and treatment-related classification reasons. As prisons become full, tensions mount and deprivations begin to multiply; administrators must have sufficient degrees of freedom to respond to the special needs and conflicts that inevitably result. When every cell or dormitory bed is filled, the degrees of freedom administrators have to address problems are correspondingly reduced; in prison, especially, unaddressed problems eventually worsen.

B. Chronic Overcrowding Inside the ADOC

126. Alabama's prisons have been dangerously overcrowded for decades. According to the Council of State Governments, Alabama has "the most crowded prison system in the nation,"[12] and the State has had this distinction for a very long time. As a result, prison officials have undertaken

[12] Council of State Governments, Alabama [available at: https://csgjusticecenter.org/jr/al/].

policies and practices designed to accommodate significant—and dangerous—levels of overcrowding. Over time, those policies and practices have come to be regarded as "normal" and acceptable. Thus, for overcrowding-related reasons, the quality of life inside ADOC facilities has greatly deteriorated over a very long period of time and, correspondingly, the physical safety and the mental health of the people who live and work there have been jeopardized as a result. Yet because these levels of overcrowding have continued for such a long period of time, the troublesome practices appear to be taken for granted. No one seems to appreciate how extraordinary the deterioration is, compared to the rest of the country, how utterly destructive it is to the mental health of the prisoners (prisoners in general, but especially prisoners who are suffering from mental illness), and how truly dangerous it is (both to the well-being of the prisoners and to the long-term safety of the public at large).

127. The ADOC is currently operating at approximately 182% of capacity overall.[13] To put this figure in context, note that the United States

[13] See ADOC, Alabama Monthly Statistical Report for March, 2016 [available at: http://doc.alabama.gov/docs/MonthlyRpts/2016-03.pdf], at p. 3. As shocking as this number is—an entire prison system bordering on housing nearly twice the number of prisoners it was designed to hold—like all such overall or system-wide calculations, it can mask even more significant (and more dangerous) levels of overcrowding at specific facilities and specific kinds of facilities. Thus, "medium security" prisons in Alabama hold 200% of their design capacity, and "minimum security"/"work centers" are operating at 271% of their design capacity. *Id.* at p. 3.

Supreme Court in 2011 upheld a lower court order (in a trial in which I testified), mandating the state of California to reduce its prison population by some 40,000 prisoners in order to reach the absolute upper operable limit of 137.5%,[14] approximately 45% lower than the overall level of overcrowding at which the ADOC is currently operating (and has been operating for some time). The Court reached the same conclusion that the lower court had on precisely this issue: the California prison system simply could not deliver constitutionally adequate medical or mental health care at a level of overcrowding any higher than 137.5%. This conclusion was reached even after California had spent years (two decades in the case of mental health care) and invested literally billions of dollars attempting to improve its prison health and mental health care. The ADOC, where I have seen no evidence of any recent, concerted, comparable attempts or major expenditures designed to improve prison health and mental health care or to remedy the manifold problems discussed in this Report, continues to operate at a level of overcrowding that is far above the upper limit the Supreme Court imposed on California.

C. *The Psychological Effects of Overcrowding on Prisoners*

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[14] *Brown v. Plata*, 131 S.Ct. 1910 (2011).

128. There are a number of basic facts of life in overcrowded prisons that generate a wide range of unpleasant, harmful, and potentially very dangerous and damaging effects. As a group of prison researchers concluded several decades ago, "crowding in prisons is a major source of administrative problems and adversely affects prisoner health, behavior, and morale."[15] When the overcrowding is chronic and severe, as it is in the ADOC, these effects are amplified. They are especially amplified for mentally ill prisoners, who have a difficult time more generally managing the stress of normative prison life, and are more reactive and vulnerable to the pressures and unpredictability that overcrowded prison conditions bring about. When this dynamic is combined with a deterioration in the delivery of mental health services, as it clearly is in the ADOC, mentally ill prisoners experience the worst of both worlds—a dangerous and damaging

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[15] Vernon Cox, Paul Paulus, and Garvin McCain, *Prison Crowding Research: The Relevance for Prison Housing Standards and a General Approach to Crowding Phenomena*, 39 American Psychologist 1148 (1984); G. Gaes, *The Effects of Overcrowding in Prison*, Crime and Justice: Annual Review of Research (M. Tonry & N. Morris, eds.) (1985); Paul Paulus, *Prison Crowding: A Psychological Perspective,* New York: Springer-Verlag (1988). Two other early commentators concluded their review of the literature in much the same way, namely, that "[w]ith few exceptions, the empirical studies indicate that prison overcrowding has a number of serious negative consequences." T. Thornberry & J. Call, *Constitutional Challenges to Prison Overcrowding: The Scientific Evidence of Harmful Effect*, 35 Hastings Law Journal 313, 351 (1983). Overcrowding studies at women's prisons showed similar effects. See Barry Ruback & Timothy Carr, *Crowding in a Woman's Prison: Attitudinal and Behavioral Effects*, 14 Journal of Applied Social Psychology 57-68 (1984).

set of living conditions and a compromised (or essentially non-existent) therapeutic response. In the following paragraphs I first discuss the general negative effects of overcrowding in prison, and then the way in which these adverse consequences are greatly amplified for mentally ill prisoners.

129. For one, crowding intensifies the basic pains of imprisonment. Prisoners living in overcrowded prisons are forced to interact with more unfamiliar people, under extremely close quarters that afford little or no privacy or respite, where their basic needs are less likely to be addressed or effectively met. The frequency of interactions, the sheer numbers of violations of personal space that occur, the forced closeness of the contact, and the inability to create moments of respite or tranquility (however fleeting) all combine to create very high levels of psychological stress. Prisoners in overcrowded prisons are more idle—because there are fewer meaningful activities available in which they can engage—but they are also more on edge. It is a dangerous combination.

130. Overcrowding thus operates, at an individual level, to worsen the experience of imprisonment by literally changing the nature of the environment to which prisoners must adapt or cope on a day-to-day basis. The coping mechanisms that they develop—ones undertaken in order to survive the experience—often take a psychological toll. And the longer

someone is exposed to overcrowded conditions, the greater the length of time during which problematic coping mechanisms can evolve in response.[16] Thus, all other things being equal, short-term overcrowding is less problematic than exposure to long-term or chronically overcrowded prison conditions. In addition to these direct, individual-level effects, which I will discuss in a subsequent section, overcrowding also changes the way the prison itself functions.

131. Not surprisingly, a large literature on overcrowding has documented a range of adverse effects that occur when prisons have been filled to capacity and beyond. Although other variables may mediate or reduce the negative effects of crowding,[17] the overcrowding can take a direct and substantial psychological toll. Researchers have documented the extent

[16] For example, see the discussion in J. Bonta, *Prison Crowding: Searching for the Functional Correlates*, 41 American Psychologist 99-101 (1986), and the references cited therein.

[17] For example, see S. Ekland-Olson, *Crowding, Social Control, and Prison Violence: Evidence From the Post*-Ruiz *Years in Texas*, 20 Law and Society Review 389 (1986). However, one of the reasons that quantitative measures of the adverse effects of prison crowding sometimes yield inconsistent results has to do with this basic fact of prison life: The prison and the prison staff also react and adjust to the levels of overcrowding, setting in motion a chain of events that changes what is being measured and how. Thus, for example, the ability of staff to identify disciplinary infractions, and how they react to and punish those that are identified, may change in unpredictable ways as a prison becomes increasingly overcrowded.

to which prison overcrowding increases negative affect among prisoners,[18] elevates their blood pressure,[19] and leads to greater numbers of prisoner illness complaints.[20] Not surprisingly, exposure to "long-term, intense, inescapable crowding" of the sort that has characterized Alabama's prisons for decades results in high levels of stress that "can lead to physical and psychological impairment."[21] In addition, a number of studies have found that overcrowding is associated with higher rates of disciplinary infractions, especially among younger prisoners.[22] For example, one study concluded

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[18] E.g., Paul Paulus, Vernon Cox, Garvin McCain, & J. Chandler, *Some Effects of Crowding in a Prison Environment*, 5 Journal of Applied Social Psychology 86, 90 (1975): "The present study indicates that living under relatively crowded housing conditions in a prison produces both negative affect and a lower criterion of what constitutes overcrowding."

[19] E.g., D. D'Atri, *Psychophysiological Responses to Crowding*, 7 Environment and Behavior 237, 247 (1975): "[T]he major hypothesis that there would be an association between degree of crowding and blood pressure, systolic and diastolic, was strongly supported."

[20] E.g., G. McCain, V. Cox & P. Paulus, *The Relationship Between Illness Complaints and Degree of Crowding in a Prison Environment*, 8 Environment and Behavior 283, 288 (1976).

[21] P. Paulus, G. McCain, & V. Cox, *Death Rates, Psychiatric Commitments, Blood Pressure, and Perceived Crowding as a Function of Institutional Crowding*, 3 Environmental Psychology and Nonverbal Behavior 107,115 (1978). See, also, Adrian Ostfeld, Stanislav Dasl, David D'Atri & Edward Fitzgerald, *Stress. Crowdin,. and Blood Pressure in Prison*, Hillsdale, NJ: Lawrence Erlbaum (1987).

[22] There are a number of studies that have documented the fact that overcrowding contributes significantly to various forms of prison aggression and infractions. For example, see: G. Gaes & W. McGuire, *Prison Violence: The Contribution of Crowding Versus Other Determinants of Prison Assault Rates*, 22 Journal of Research in Crime and Delinquency 41-65 (1985); J. Wooldredge, T. Griffin, & T. Pratt, *Considering*

that in prisons "where crowded conditions are chronic rather than temporary and where people prone to antisocial behavior are gathered together, there is a clear association between restrictions on personal space and the occurrence of disciplinary violations."[23] There is also evidence to suggest that psychiatric patients are more likely to become aggressive in housing units that lack adequate bed space and are overcrowded.[24]

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*Hierarchical Models for Research on Prisoner Behavior: Predicting Misconduct With Multilevel Data*, 18 Justice Quarterly 203-231 (2001) (overcrowding predicted prisoner misconduct in the New York, Washington, and Vermont prison systems). This appears to especially true in prisons that house "younger" prisoners (e.g., where their median age is 27 years or less). For example, see: S. Ekland-Olson, D. Barrick, & L. Cohen, *Prison Overcrowding and Disciplinary Problems: An Analysis of the Texas Prison System*, *19 Journal of Applied Behavioral Sciences* 163-176 (1983); and J. Nacci, J. Prather, & H. Teitelbaum, *The Effect of Prison Crowding on Prisoner Behavior*, Washington, DC: U.S. Bureau of Prisons (1977). Thus, a "meta analysis" (a statistical procedure that combines the results of a number of different studies) concluded that although overcrowding did not appear to have a significant effect on misconduct within the prison population as a whole, it did have "substantially larger effects among younger prisoners, consequently leading to higher levels of violent and nonviolent misconduct among younger prisoner populations." T. Franklin, C. Franklin, & T. Pratt, *Examining the Empirical Relationship Between Prison Crowding and Prisoner Misconduct: A Meta-Analysis of Conflicting Research Results*, 34 Journal of Criminal Justice 401-412 (2006).

[23] E. Megargee, *The Association of Population Density, Reduced Space, and Uncomfortable Temperature with Misconduct in a Prison Community*, 5 American Journal of Community Psychology 289, 295 (1977).

[24] For example, see: B. Ng, S. Kumar, M. Ranclaud, & E. Robinson, *Ward Crowding and Incidents of Violence on An Acute Psychiatric Inpatient Unit*, 52 Psychiatric Services 521-525 (2001); and Palmstierna, et al., *The Relationship of Crowding and Aggressive Behavior on a Psychiatric Intensive Care Unit*, 42 Hospital and Community Psychiatry 1237-1240 (1991).

132. Among other things, overcrowded prisons generate increased noise levels, and temperatures inside them can be elevated to intolerable levels during summer months, both of which can increase irritability among staff and prisoners. In addition, overcrowding makes it more difficult for staff to effectively monitor prisoner behavior because of the sheer number of people whom they must oversee. Overcrowded housing units are more difficult to keep clean, more likely to fall into disrepair and suffer more frequent breakdowns in plumbing and other basic services. Unintentional violations of personal space are not only more likely in overcrowded prisons but are also, in turn, more often perceived as provocations (and responded to accordingly, by both prisoners and staff). In fact, perhaps in part because the subjective experience of prison crowding is so stressful, researchers have found that it not only puts prisoners chronically "on edge," but also leads them to perceive others in their surrounding environment as more hostile and intentionally malevolent, increasing their readiness to react to those others as threatening.[25] For perhaps obvious reasons, this is especially true for prisoners with pre-existing mental health problems,

[25] For example, see: C. Lawrence & K. Andrews, *The Influence of Perceived Prison Crowding on Male Prisoners' Perception of Aggressive Events*, 30 Aggressive Behavior 273-283 (2004).

many of whom feel more vulnerable and otherwise at risk in environments they experience as hostile.

133. Prison overcrowding also affects prisoners' mental and physical health by increasing the level of uncertainty with which they regularly must cope. Thus, overcrowded prison conditions heighten the level of cognitive strain that prisoners experience by introducing greater social complexity, turnover, and interpersonal instability into an already dangerous environment where interpersonal mistakes or errors in social judgments can be fatal. Of course, overcrowding also raises collective frustration levels inside prisons by generally decreasing the resources, programming, and other activities that are available to the prisoners confined in them. The sheer number of things prisoners can do or accomplish on a day-to-day basis is compromised by the increasingly scarce resources and the multiplicity of people between whatever goals they try to achieve and whatever places they go inside prison, such as yard, chow, pill call, and so on.[26] Here, too, these issues are especially problematic for mentally ill

[26] For example, see: Vernon Cox, Paul Paulus, & Garvin McCain, *Prison Crowding Research*, 39 American Psychologist 1148,1159 (1984). See also, Edward Sieh, *Prison Overcrowding: The Case of New Jersey*, 53 Federal Probation 41-51 (1989) for a brief review. For a discussion of the health risks of prison and jail overcrowding, see Bailus Walker & Theodore Gordon, *Health Risks and High Density Confinement in Jails and Prisons*, 44 Federal Probation 53-58 (1980).

prisoners who already struggle with social interaction (even under the best of circumstances), are often prone to suspicion and paranoia, and who have a difficult time navigating complicated situations generally.

134. One widely cited literature review concluded that although prisons in general are not necessarily harmful to all prisoners, overcrowded prisons certainly are. The review included these empirically documented observations: that "physiological and psychological stress responses … were very likely [to occur] under crowded prison conditions"[27]; that "a correlation [has been found] between population density and misconduct [when age is used as a moderator variable]"[28]; that there is "a significant relationship between crowding and post-release recidivism"[29]; and that "high prisoner turnover [in some prisons has been found to predict] prisoner disruptions."[30] The reviewers also acknowledged that "as sentence length or exposure to crowded situations increase so does the risk for

[27] James Bonta & P. Paul Gendreau, *Reexamining the Cruel and Unusual Punishment of Prison Life*, 14 Law and Human Behavior 347-372, 353 (1990).

[28] *Ibid.*

[29] *Ibid.* at 354.

[30] *Ibid.*

misconduct"[31]; and that "[w]hen threats to health come from suicide and self-mutilation, then prisoners are clearly at risk."[32]

135. Prisoners confined in chronically and severely overcrowded prisons live in housing units that deteriorate and become dilapidated more rapidly. I witnessed exactly these effects throughout the ADOC facilities that I toured and inspected. Overcrowded prisons such as the ones I saw in the Alabama prison system are dirtier and their infrastructure is in greater disrepair because of the overuse they receive. In extreme cases, prisoners may be herded into inappropriate housing that affords them even less privacy and safety than the already minimal amount that standard prison cells provide. This is clearly the case in Alabama, where the questionable use of crowded dormitory housing, including cases where maximum security prisoners are housed in close proximity to the mentally ill and other vulnerable prisoners, is widespread.

136. The more degraded conditions under which prisoners live in overcrowded prisons underscore their compromised and stigmatized social status and role. These same factors may further diminish their sense of self-worth and personal value. Like the rest of us, of course, prisoners derive

[31] *Ibid.*

[32] *Ibid.* at 356.

symbolic meaning from and internalize the messages that come from the way they are treated. When they are treated in harsh and humiliating ways, and are confined in abysmal housing units, many come to think of themselves as deserving no more than the degradation and stigma to which they are being subjected.[33] This degraded identity may be difficult or impossible to relinquish when released from prison.

137. Of course, many prisoners enter overcrowded prison systems with pre-existing psychological problems and psychiatric disorders. This is clearly true in the ADOC, where seriously mentally ill prisoners were scattered throughout the general populations and Segregation Units in the facilities that I toured and inspected. Yet, because mentally ill prisoners are especially sensitive to the harsh realities of overcrowded prisons, they are more likely to suffer and deteriorate in these environments. More specifically, they are more likely to be adversely affected by the forced intimate contact that overcrowded housing units require because, depending on the nature of their illness, they may be far less adept at

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[33] These issues have been explored in classic sociological writing. See, for example: R. Homant, *Employment of Ex-Offenders: The Role of Prisonization and Self-Esteem*, 8 Journal of Offender Counseling, Services, & Rehabilitation 5-23 (1984); J. Irwin, *The Felon*, Englewood Cliffs, NJ: Prentice-Hall (1970); L. McCorkle, & R. Korn, *Resocialization Within Walls*, 293 The Annals 88-98 (1954); C. Title, *Institutional Living and Self-Esteem*, 20 Social Problems 65-77 (1972); and R. Wulbert, *Prisoner Pride in Total Institutions*, 71 American Journal of Sociology 1-9 (1965).

reading social cues, controlling their impulses, or regulating their emotional states than the prisoners with whom they must so closely and constantly interact. The decreased opportunities for normal, non-pressured social interaction may undermine already impaired reality testing. And the sheer stress of severely overcrowded confinement may overwhelm their already fragile coping mechanisms, creating fear and anxiety in what these prisoners experience as an increasingly unpredictable world. Thus, mentally ill prisoners are more likely to decompensate from exposure to such pressurized, overcrowded environments, and they are vulnerable to victimization from the overcrowding-related conflicts that occur with increased frequency.

138. Unfortunately, and for obvious reasons, chronically and severely overcrowded prison systems struggle to obtain and retain adequate numbers of clinical staff and to implement treatment programs that address the needs of this special population. The shortage of treatment staff translates into a failure to effectively address the clinical needs of mentally ill prisoners. In the ADOC, this problem is widespread and endemic and it helps to account for the systemic failure to address the basic treatment needs of Alabama's mentally ill prisoners. Thus, overcrowding threatens the already fragile condition of vulnerable mentally ill prisoners and

understaffing ensures that their immediate problems are unlikely to be adequately addressed. More suffering and more serious forms of decompensation, including higher rates of suicide and self-harm, are the predictable results.

139. In addition, chronic and severe overcrowding can generate mental health problems among prisoners who come into prison without any pre-existing psychiatric disorders. For many prisoners, the mere exposure to severe conditions of confinement is a form of trauma. Thus, compared to the population at large, a much higher percentage of prisoners develop "post-traumatic stress disorder" (PTSD)—a range of long-term trauma-related symptoms, including depression, emotional numbing, anxiety, isolation, hypervigilance, and related reactions—than in the freeworld.[34] In this regard, psychiatrist Judith Herman and others have proposed that the diagnostic category of post-traumatic stress disorder be restructured to include what she has termed "complex PTSD," a disorder

[34] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 4th Edition (pp. 111), Washington, DC: American Psychiatric Association (1994). For more detailed discussions of the disorder, see C. Peter Erlinder, *Paying the Price for Vietnam: Post-Traumatic Stress Disorder and Criminal Behavior*, 25 Boston College Law Review 305 (1984); J.E. Helzer, L.N. Robins, & L. McEvoy, *Post-Traumatic Stress Disorder in the General Population*, 1317 The New England Journal of Medicine 1630-1634 (1987); A.B. Rowan, D.W. Foy, N. Rodriguez, & S. Ryan, *Posttraumatic Stress Disorder in a Clinical Sample of Adults Sexually Abused as Children*, 18 Child Abuse and Neglect 51-61 (1994); John P. Wilson and Beverly Raphael (Eds.), *International Handbook of Traumatic Stress Syndromes,* New York: Plenum (1993).

created by "prolonged, repeated trauma or the profound deformations of personality that occur in captivity."[35] Complex PTSD can result in protracted depression, apathy, and the development of a profound sense of hopelessness. For some prisoners, it represents the long-term psychological cost of adapting to oppressive forms of prison confinement.[36] But overcrowding heightens levels of traumatic violence and increases exposure to this and other emotionally wrenching events that can have long-lasting psychological consequences.

140. In any event, many prisoners react to the pains of chronically and severely overcrowded prisons by developing overt psychological symptoms or experiencing an exacerbation of ones that already exist—including clinical depression, paranoia, psychosis, and PTSD.[37]

D. *The Behavioral Effects of Overcrowding on Prisoners and Prisons*

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[35] Judith Herman, *A New Diagnosis*, Trauma and Recovery (Judith Herman, ed.),(pp. 119) New York: Basic Books (1992). See, also, Judith Lewis Herman, *Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma,* Psychotraumatology: Key Papers and Core Concepts in Post-Traumatic Stress (George S. Everly Jr. & Jeffrey M. Lating, eds.) (pp. 87-100), New York: Plenum (1995).

[36] Judith Herman, *Complex PTSD: A Syndrome in Survivors of Prolonged and Repeated Trauma*, 5 Journal of Traumatic Stress 377-391 (1992).

[37] Cf. R. DeWolfe & A. DeWolfe, *Impact of Prison Conditions on the Mental Health of Prisoners*, 1979 Southern Illinois University Law Journal 497 (1979); Hans Toch, *Men in Crisis: Human Breakdowns in Prison*, Chicago, IL: Aldine (1975); Hans Toch, *Living in Prison: The Ecology of Survival*, New York: Free Press (1977).

141. Prison systems, administrators, and staff also respond to overcrowding in a variety of ways that, in turn, impact prisoner behavior. In an important sense, of course, in addition to adversely affecting individuals, overcrowding is a systemic or system-level problem. Prison systems "behave" differently in the face of it, and few, if any of their adaptations have long-term positive consequences.

142. For one, overcrowded prison systems often respond to the influx of numbers of prisoners by reducing the amount of screening, monitoring, and effective managing that they perform. This typically includes compromises that are made in the assessment and treatment of vulnerable or special needs prisoners. As one group of clinicians acknowledged in terms that apply directly to the overcrowded ADOC: "Unfortunately, the prospect of screening prisoners for mental disorder and treating those in need of mental health services has become a daunting and nearly impossible task in the present explosion of prison growth."[38] Unidentified and untreated mentally ill prisoners in mainline prison populations not only are more likely to deteriorate themselves but also to

[38] Frank DiCataldo, Alexander Greer & Wesley Profit, *Screening Prison Prisoners for Mental Disorder: An Examination of the Relationship Between Mental Disorder and Prison Adjustment*, 23 Bulletin of the American Academy of Psychiatry and Law 573-585, 574 (1995).

have a significant adverse effect on the prisoners with whom they must live and interact—sometimes incurring their wrath and provoking mistreatment.

143. Overcrowding also means that prison systems experience pressures to reallocate already limited programming and other resources to create bed space and maintain basic security. Significant reductions in correctional services, activities, programming, and treatment for increased numbers of prisoners translates into higher levels of idleness. Put simply, a severely and chronically overcrowded prison system like the one that now exists in Alabama cannot keep the majority of its prisoners meaningfully or productively engaged in activities and programs.

144. Moreover, chronic idleness produces more than mere boredom. There is widespread agreement among correctional experts that empty, idle time in prison produces negative psychological and behavioral effects. As far back as the 1980s, when the trends toward overcrowding and the lack of prison programming had just begun, the U.S. Government Accounting Office noted: "Corrections officials believe that extensive prisoner idleness can lead to destructive behavior and increase violence within institutions.

Moreover, idleness does little to prepare prisoners for re-entry into society."[39]

145. Idleness-related frustration also increases the probability of interpersonal conflict and assaults in prison. Unfortunately, as I noted earlier, overcrowding simultaneously reduces the opportunities for staff to effectively monitor prisoner behavior and drastically limits their options to reduce animosities between prisoners by separating them or sending them to different facilities. Thus, there is greater stress and more opportunity for interpersonal conflict, less for prisoners to do, fewer positive or productive outlets to release the resulting tension, decreased staff capacity to identify prisoner problems, and fewer options to solve them once they do.[40]

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[39] United States Government Accounting Office, *Report to the Attorney General: Improved Prison Work Programs Will Benefit Correctional Institutions and Prisoners* 2 (1982).

[40] As I noted earlier, overcrowding appears to have especially adverse effects on the institutional behavior of younger prisoners. Thus, one study of the Texas prison system found that:

> The greater the proportion of young prisoners housed in the institution, the greater the infraction and assault rates. There is some evidence for an interaction effect between age and prison size. Younger prisoners may be more susceptible to the problems and control structures in large prisons than older prisoners.

S. Ekland-Olson, D. Barrick, & L. Cohen, *Prison Overcrowding and Disciplinary Problems: An Analysis of the Texas Prison System*, 19 Journal of Applied Behavioral Science 163-176,174 (1983); Gilbert Gaes and William McGuire, *Prison Violence: The Contribution of Crowding Versus Other Determinants of Prison Assault Rates*, 22 Journal of Research in Crime and Delinquency 41-65 (1985). Another study obtained

146. Moreover, the kind of widespread idleness and lack of purposeful activity that pervades overcrowded prisons has been identified as a major cause of self-harm and suicide among prisoners.[41] Indeed, a 2005 nationwide study of prison suicides found that the "the probability of suicide increases dramatically as overcrowding increases…"[42] These researchers found that suicide rates were lower in minimum security facilities overall—presumably because of the greater levels of program participation—but that overcrowding actually produced the greatest effect on the suicide rate at these facilities. That is, at high levels of overcrowding, minimum security prisons were as likely to experience suicide as their medium and maximum security counterparts. In fact, some prison researchers have concluded that one of the best ways to decrease the rate

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similar results, with overall correlations that revealed "a significant association between density and total assaults and assaults on prisoners" such that the greater the density the more frequent the assaults. But the relationship between crowding and violence was "strongest in the institutions housing young offenders." P. Nacci, H. Teitelbaum, & J. Prather, *Population Density and Prisoner Misconduct Rates in the Federal Prison System*, 41 Federal Probation 26, 29 (1977).

[41] For example, see: *M. Leese, S. Thomas, & L. Snow, An Ecological Study of Factors Associated with Rates of Self-inflicted Death in Prisons in England and Wales*, 29 International Journal of Law and Psychiatry 355-360 (2006).

[42] M. Huey & T. McNulty, *Institutional Conditions and Prison Suicide: Conditional Effects of Deprivation and Overcrowding*, 85 Prison Journal 490-514, 506 (2005).

(not just the absolute number) of prison suicides is to reduce the total number of incarcerated persons.[43]

147. Another negative behavioral effect of overcrowding that stems from the changes it produces at both individual and institutional levels is the increased risk of sexual victimization. For example, one prison researcher has noted that "[i]n less well-regulated institutions in which prisoners have little recourse to protection or in which there may be collusion between dominant prisoners and staff to maintain the peace, sexual violence tends to be greater."[44] Others have suggested that overcrowded conditions in which prisoners have much idle time may contribute to higher numbers of prison rapes.[45]

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[43] For example, see: P. Marcus & P. Alcabes, *Characteristics of Suicides by Prisoners in an Urban Jail*, *44* Hospital and Community Psychiatry 256-261 (1993); and D. MacDonald & N. Thomson, *Australian Deaths in Custody, 1980-1989*, 159 Medical Journal of Australia 581-585 (1993). Of course, no one would argue that a simple reduction in population is all that is needed to address suicidality among prisoners. Clearly, a corresponding concern for the needs of the prisoners who remain in prison, as well as those who are released or diverted to non-prison settings, is also needed. For example, see: S. Fruehwald, P. Frottier, K. Ritter, R. Eher, & K. Gutierrez, *Impact of Overcrowding and Legislational Change on the Incidence of Suicide in Custody Experiences in Austria*, 1967-1996, 25 International Journal of Law and Psychiatry 119-128 (2002), who argue that reductions in prisoner populations must be accompanied by suicide prevention training among custodial staff.

[44] M. King, *Male Rape in Institutional Settings*, Male Victims of Sexual Assault (G. Mezey & M. King, eds.) (pp. 70), Oxford: Oxford University Press (1992).

[45] P. Gunby, *Sexual Behavior in an Abnormal Situation*, 245 Medical News 215-220 (1981).

148. Researchers also have documented greater amounts of illicit drug use among prisoners who are incarcerated in overcrowded prison settings, leading one of them to conclude that "reducing drug-related behaviors inside prison may require alleviating prison crowding…" [46] There are several plausible explanations for this relationship, including the fact that illicit drug use is more difficult to monitor and prevent in overcrowded prisons and the likelihood that prisoners will attempt to cope with the stress of overcrowded living conditions through increased drug use.

149. There are also age-related crowding effects that are not difficult to understand.[47] Younger prisoners tend to be more volatile, sensitive to their surroundings and, in general, more likely to react aggressively to the tensions and conflicts that crowded conditions of confinement generate. However, prison officials and staff members often respond to these crowding-related infractions by punishing prisoners, frequently by placing them in disciplinary segregation units. The heightened reactivity of younger prisoners to the context of crowded living conditions means that greater

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[46] W. Gillespie, *A Multilevel Model of Drug Abuse Inside Prison*, 85 Prison Journal 223-246, 21 (2005). Perhaps not surprisingly, Gillespie found that the overcrowding effect appeared to be particularly pronounced among prisoners with a prior history of street drug use.

[47] For example, see note 22.

numbers of them will be exposed to even harsher conditions in the segregated or isolated housing units where they will be confined.

150. A number of adverse and presumably unintended long-term consequences are likely to follow from this scenario. Prison officials typically use a prisoner's disciplinary segregation status to bar him from participation in any form of educational or vocational programming. Moreover, time spent in segregation simultaneously places prisoners at risk of developing a host of adverse psychological reactions that are associated with long-term isolation (that I will discuss in the next section of this report). The absence of even minimal forms of programming and exposure to potentially disabling solitary confinement jeopardize subsequent adjustment in the mainline prison population as well as in the freeworld. And, once these prisoners do return to general population, they may well find that their prior disciplinary status leads more readily (or even automatically) to their classification as a present security risk, making them prime candidates for assignment to a segregation unit once again.

151. In light of the large number of negative individual and institutional effects of prison overcrowding, it is not surprising that several studies have suggested that crowded prisons are associated with increased

recidivism.[48] Long-term "criminogenic" or crime-producing overcrowding effects can occur in a variety of ways. Indeed, severely overcrowded prison systems can generate numerous problems that may reverberate back into the community and, eventually, back into the prison system itself. For example, because prisoners lack sufficient programming and treatment in overcrowded systems, they are more likely to re-enter the free society no better—and often much worse—than they left. This is especially true for mentally ill prisoners whose psychiatric conditions are likely to worsen in the face of the harsh and punitive conditions they face in overcrowded prisons. If mentally ill prisoners do not receive proper, effective treatment in prison, they will return home with mental health needs that local

[48] For example, at the start of the 1980s, several British researchers found a strong relationship between overcrowding and prison ineffectiveness in England—prisoners released from overcrowded prisons were more likely to be recommitted for subsequent criminal infractions. The relationship could not be explained away by other variables, leading the researchers to recommend a reduction in prison overcrowding in order to improve the ability of prisons to reduce crime. By sending fewer people to prison or by reducing the effective lengths of prison sentences, they argued, the effectiveness of prison might be enhanced. D. Farrington & C. Nuttall, *Prison Size, Overcrowding, Prison Violence, and Recidivism*, 8 Journal of Criminal Justice 221-231, 230 (1980). Similarly, several years after this English study, Canadian researchers concluded that placing low-risk offenders in often-overcrowded high security facilities resulted in high rates of re-incarceration. J. Bonta & L. Motiuk, *The Diversion of Incarcerated Offenders to Correctional Halfway Houses*, 24 Journal of Research in Crime & Delinquency 302 (1987). The rates were significantly higher than those of comparable low-risk offenders who had been placed in halfway houses. The researchers concluded that the failure to properly divert low-risk offenders from high to low security facilities—something that overcrowded prison systems often lack the capacity to do—"may actually increase the risk of future recidivism." *Id*. at 312.

communities with already limited treatment resources will be called upon to address. Mentally ill prisoners who worsen or decompensate in prison will need even higher levels of care and, in extreme cases, they may become chronically or even permanently disabled. Untreated or worsened mental health conditions also may render some prisoners more dangerous when they return from prison than when they left.

152. In addition, prisoners who are traumatized by severely overcrowded prison conditions or exposure to the extreme forms of violence that can occur within them may leave prison with psychiatric disorders that they did not have or did not manifest as clearly at the outset of their prison sentences. That is, as I noted earlier, prisoners can enter prison without a documented history of mental illness but, because of the severe deprivations, profound indignities, and dangerous conditions they confront, develop serious trauma-related disorders that may require mental health treatment both in prison and later in free society. In the absence of such treatment, these prisoners are prime candidates to re-offend.

153. Thus, overcrowded prisons tend to beget overcrowded prisons. In fact, Alabama is a perfect example of the way in which a chronically and severely overcrowded prison system sends prisoners back into the community ill-prepared to successfully reintegrate there. Increasing

numbers of them are at greater risk of re-offending or violating the conditions of their parole more quickly and repeatedly, which in turn would generate greater numbers of prisoners and exacerbate the prison overcrowding problem.

E. *The Relationship Between Overcrowding and the Overuse of Segregation*

154. As I have already noted, an unprecedented influx of prisoners compromises the meaningful evaluation, classification, and appropriate assignment of incoming prisoners. In a severely overcrowded prison system such as the ADOC, in addition to a prisoner's security level, available bed space largely determines subsequent housing assignments. This means that many fewer new prisoners pass through an intake process that includes a comprehensive diagnostic evaluation, decreasing the likelihood that they will be assigned to prisons that will adequately address their mental health as well as their educational or vocational needs. Indeed, ADOC's chronically and severely overcrowded prisons for the most part lack the resources with which to address the broad range of prisoner needs and problems anyway.

155. Among other things, this means that prison administrators have few incentives or positive rewards at their disposal with which to manage and control prisoner behavior. That is, overcrowded prisons lose their programming orientation and options. They are rarely in a position to offer

well-behaved prisoners meaningful opportunities for personal growth or skill development, or participation in engaging activities or thriving organizations as "carrots" to reinforce and shape prisoner behavior. Lacking carrots, overcrowded prisons and prison systems rely increasingly on "sticks." Thus, overcrowding leads to increasingly negative forms of institutional control and, as population pressures mount, the use of harsh discipline and punishment tends to escalate.

156. The use of harsher and more punitive policies and procedures to maintain order and control means that custody staff increasingly rely on punishment—typically in the form of isolated confinement in Segregation Units—to control prisoner behavior. Indeed, correctional officers' interpersonal skills atrophy in prison systems where problems are solved and conflict defused increasingly by a reflexive tendency to lock up or lock down problematic or challenging prisoners (or the entire housing units in which they reside). Indeed, overcrowded prisons more frequently employ "lockdowns" and disciplinary sanctions such as segregation that further restrict prisoner movement and keep them separated from staff as well as one another. In Alabama, as I have already noted at some length, this includes the ill-advised, dangerous, and cruel practice of placing large

numbers of mentally ill prisoners in Segregation Units, thus putting them at especially significant risk of serious psychological harm.

157. This ill-advised, dangerous, and cruel practice, and the potential for serious harm that it causes, is illustrated by the case of Mr. Joshua Dunn, the lead Plaintiff in this litigation. At his deposition, Mr. Dunn testified that he had been hospitalized for mental health problems as a teenager and prescribed psychotropic medications upon his release from the institution.[49] He was diagnosed as suffering from bi-polar disorder and ADHD before coming to prison,[50] and had twice attempted suicide, once on the street and once in jail.[51] At St. Clair, Mr. Dunn was stabbed 15 times by another prisoner and subsequently placed in Segregation (although the person who stabbed him remained in general population).[52] Mr. Dunn was placed in Segregation and, while there, he repeatedly asked to see mental health staff—"I would holler out my window and say I needed to talk to her, I was going through some things. She kept saying when she got time she'd

[49] Deposition of Joshua Dunn, December 8, 2014 (hereafter "Dunn Deposition") at p. 56.

[50] Dunn Deposition at p. 122.

[51] Dunn Deposition at p. 138.

[52] Dunn Deposition at p. 134.

get to me, she'd have an officer bring me over. But I never seen her."[53] He said that he told staff that he intended to hurt himself, and requested mental health treatment "[a]t least six" times while in Segregation, but received no such treatment.[54] Mr. Dunn cycled back and forth between Segregation and Suicide Watch, despite having been diagnosed with mental health problems and documented instances of self-harm. Eventually, Mr. Dunn cut himself with a razor blade while in a Crisis Cell in the Infirmary at St. Clair.[55] On a different occasion, he cut himself while in Segregation and was left "for four hours after I cut myself, bleeding,"[56] before being transported to an outside hospital. He also described a time when he was "left in a suicide cell buck naked for three weeks…"[57] Although he testified that he feels he needs appropriate medication and counseling for his psychiatric problems, he had not received it as of the date of his

[53] Dunn Deposition at p. 145.

[54] Dunn Deposition at p. 146-7.

[55] Dunn Deposition at p. 153.

[56] Dunn Deposition at p. 161. He said that nurses ignored his bleeding "because they said I do it all the time, let me lay in there and die. 'If he's going to keep cutting himself, let him lay there and die.'" At p. 221. In the course of being questioned about these issues, an attorney representing the ADOC appeared to instruct him on the "proper" techniques to follow in order to actually kill himself. At p. 291-2.

[57] Dunn Deposition at p. 182. Mr. Dunn also said that, even when he was seen by mental health in the Suicide Watch Cell in the Infirmary, the staff member merely asked, "Are you ready to go back to seg? You still suicidal?" At p. 282.

deposition.[58] Despite multiple instances of self harm, Mr. Dunn remained in Segregation past his disciplinary sentence because the man who stabbed him was in the general population at the facility and, as far as he understood, ADOC did not have any other space available.[59] Mr. Dunn cut himself on at least one other occasion while in Segregation. After being treated at the Infirmary, he was sent directly back to Segregation because "they didn't have a suicide cell open in the infirmary."[60] Again, Mr. Dunn was held in Segregation, past the conclusion of his disciplinary term because of a lack of suitable alternative placements in the ADOC. The experience quite obviously increased Mr. Dunn's suffering and caused a significant risk of even greater harm.

## VI. The Harmful Psychological Effects of Segregation

158. The extensive use of segregated housing in the ADOC is so troubling in part because of the degrading nature of the conditions themselves—as I noted, in some instances, worse than anything I have ever encountered in some four decades of evaluating prison conditions. Also, as

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[58] Dunn Deposition at p. 189-91. He said that he had been taking Lithium upon his arrival into the ADOC in September, 2012, but that "[t]hey took me off of it" at intake. At p. 194.

[59] Dunn Deposition at p. 226. Apparently, mental health staff recognized the he was experiencing stress in the Segregation Unit, yet he remained there. At p. 244.

[60] Dunn Deposition at p. 229.

I noted, the practice is so widespread in the ADOC that it includes large numbers of otherwise very vulnerable and highly at risk mentally-ill prisoners, who are languishing in these terrible units. However, the practice is also problematic and troubling because it is proceeding in this way in Alabama at a time when there is a scientific, professional, human rights—and, in fact, correctional— consensus that is moving in exactly the opposite direction.

159. As I will discuss in this section of my Report, the effects of segregated or solitary-type confinement—especially over a long period of time—are now well understood and described in the scientific literature. There are numerous empirical studies that report "robust" findings—that is, the findings have been obtained in studies that were conducted by researchers and clinicians from diverse backgrounds and perspectives, were completed and published over a period of many decades, and are empirically very consistent.[61] With remarkably few exceptions, virtually

[61] See the reviews of this literature summarized in my various publications on the topic, including: Craig Haney, *Infamous Punishment: The Psychological Effects of Isolation*, 8 National Prison Project Journal 3 (1993); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, Crime & Delinquency, 49, 124-156 (2003); Craig Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 Criminal Justice and Behavior 956-984 (2008); Craig Haney, *The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful*, Prison Service Journal, 12 (2009); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: The Psychological Consequences of Solitary and Supermax Confinement*, 23 New York University Review of Law and Social Change 477-570 (1997); and Craig

every one of these studies has documented the pain and suffering that isolated prisoners endure and the significant risk of serious psychological harm to which they are exposed. It is important to emphasize, as I will discuss at the end of this section of my report, that virtually all of the effects discussed below are far more problematic and dangerous for mentally ill prisoners. Thus the risks to which the ADOC currently subjects this group of already vulnerable prisoners, by exposing them to the degraded and degrading conditions of isolated confinement where so many of them are currently housed, are truly substantial and cannot possibly be justified.

160. The empirical conclusions that have been reached in the numerous studies of solitary confinement are impressive in part because they are also theoretically sound. That is, there are straightforward scientific explanations for the fact that long-term isolation—the absence of meaningful social contact and interaction with others—and the other severe deprivations that typically occur under conditions of segregated or solitary confinement have harmful psychological consequences. Social exclusion and isolation from others is known to produce adverse psychological effects in contexts other than prison; it makes perfect theoretical sense that this

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Haney, Joanna Weill, Shirin Bakhshay, & Tiffany Winslow, *Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful,* 96 The Prison Journal 126-152 (2016).

experience produces similar negative outcomes in correctional settings, where the isolation is so rigidly enforced, the social opprobrium that attaches to isolated prisoners can be extreme, and the other associated deprivations are so severe.

161. The scientific literature on isolation, as well as my own research and experience, indicates that "long-term" exposure to precisely the kinds of conditions and practices that—based on my own personal inspections—currently exist in the ADOC, creates significant risk of serious psychological harm. The risk of harm is brought about whether or not the prisoners subjected to these conditions suffer from a pre-existing mental illness. However, for reasons that I will discuss at the end of this section of my Report, the risk is much greater for mentally-ill prisoners.

162. It should be noted, as I will discuss in more detail in several later paragraphs, that "long-term" or "prolonged" exposure to prison isolation is generally used in the literature to refer to durations of solitary confinement that are comparable to those experienced by many of the ADOC prisoners that I interviewed. For example, the American Psychiatric Association (APA) defined "prolonged segregation" as segregation lasting for four weeks or longer (which the APA also said "should be avoided" for

the seriously mentally ill).[62] I encountered a great many ADOC prisoners who had been in Segregation for many months, and many of them who had, in fact, been there for many years.

163. I should also point out that "segregation," "solitary confinement," and "isolated confinement" are terms of art in correctional practice and scholarship. For perhaps obvious reasons, total and absolute solitary confinement—literally complete isolation from any form of human contact—does not exist in prison and never has. Instead, the term is generally used to refer to conditions of extreme (but not total) isolation from others. I have defined it elsewhere, in a way that is entirely consistent with its use in the broader correctional literature, as:

> [S]egregation from the mainstream prisoner population in attached housing units or free-standing facilities where prisoners are involuntarily confined in their cells for upwards of 23 hours a day or more, given only extremely limited or no opportunities for direct and normal social contact with other persons (i.e., contact that is not mediated by bars, restraints, security glass or screens, and the like), and afforded extremely limited if any access to meaningful programming of any kind.[63]

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[62] American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012), [available at: https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Prisoners-Segregation.pdf].

[63] Haney, *The Social Psychology of Isolation, supra* note 61, at footnote 1.

164. This definition is similar to the one employed by the National Institute of Corrections (NIC), as cited by Chase Riveland in a standard reference work on solitary-type confinement that was sponsored and disseminated by the United States Department of Justice. Riveland noted that the NIC itself had defined solitary or "supermax" housing as occurring in a "freestanding facility, or a distinct unit within a freestanding facility, that provides for the management and secure control of inmates" under conditions characterized by "separation, restricted movement, and limited access to staff and other inmates."[64] More recently, the Department of Justice employed a similar definition, noting that "the terms 'isolation' or 'solitary confinement' mean the state of being confined to one's cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others… An isolation unit means a unit where all or most of those housed in the unit are subjected to isolation."[65] The isolated

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[64] Chase Riveland, *Supermax Prisons: Overview and General Considerations. National Institute of Corrections*, Washington DC: United States Department of Justice (1999) at p. 3, [available at: http://static.nicic.gov/Library/014937.pdf].

[65] United States Department of Justice, Letter to the Honorable Tom Corbett, Re: *Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation*, May 31, 2013, (emphasis in original) at p. 5, [available at: http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf], citing also to *Wilkinson v. Austin*, 545 U.S. 209, 214, 224 (2005), where the United States Supreme Court described solitary confinement as limiting human contact for 23 hours per day; and *Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990), where the Third Circuit described it as limiting contact for 21 to 22 hours per day.

confinement to which ADOC prisoners are subjected in the various Segregation Units, Stabilization Units, and even the closed RTUs (at Donaldson) very clearly fall under the definition of what is commonly understood to be solitary confinement.

A. *Scientific Research on the Painful and Harmful Effects of Solitary Confinement*

165. In the admitted absence of a single "perfect" study of the effects of solitary confinement,[66] there is a substantial body of published literature that clearly documents the distinctive patterns of psychological harm that can and do occur when persons are placed in isolation. These broad patterns have been consistently identified in personal accounts written by persons confined in isolation, in descriptive studies authored by mental health professionals who worked in many such places, and in systematic research conducted on the nature and effects of solitary confinement. The studies have now spanned a period of more than four decades, and were conducted in locations across several continents by researchers with

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[66] A "perfect" or even near-perfect study of solitary confinement would be relatively straightforward to design but, in the context of an actual prison, practically impossible to ever implement, which is why no such study has been or is likely to ever be conducted.

different professional expertise, ranging from psychiatrists to sociologists and architects.[67]

166. Even prisoners in "isolated confinement" who are "double-celled" (i.e., housed with another prisoner) may nonetheless suffer many of the negative psychological effects that are described in the paragraphs below. In fact, in some ways, prisoners who are double-celled in an isolation unit have the worst of both worlds: they are "crowded" in and confined with another person inside a small cell but—and this is the crux of their "isolation"—simultaneously isolated from the rest of the mainstream prisoner population, deprived of even minimal freedom of movement, prohibited from access to meaningful prison programs, and denied opportunities for any semblance of "normal" social interaction.[68]

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[67] For example, in addition to the literature reviews contained in my own published writing on these issues, cited at note 61, see: B. Arrigo & J. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and What Should Change*, 52 International Journal of Offender Therapy and Comparative Criminology, 622-640 (2008); and P. Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, Crime and Justice, Volume 34 (Michael Tonry, ed.) (pp. 441-528), Chicago: University of Chicago Press (2006). My own work on these issues builds on the work of those other researchers and my findings and conclusions are consistent with and corroborative of them.

[68] This is especially problematic if prisoners are involuntarily double-celled, have little or no choice over the identity of the person with whom they are double-celled, and have no practical or feasible means of changing cellmates if they become incompatible. Even under the best of circumstances, however, double-celling under conditions of otherwise isolated confinement may be difficult for prisoners to accommodate to.

167. As I noted in passing above, researchers and practitioners know that meaningful social interactions and social connectedness can have a positive effect on people's physical and mental health and, conversely, that social isolation in general is potentially very harmful and can undermine their health and psychological well-being.[69] Not surprisingly, there is now a reasonably large and growing literature on the significant risk that solitary or segregated confinement poses for the mental health of prisoners. The long-term absence of meaningful human contact and social interaction, the enforced idleness and inactivity, the oppressive security and surveillance procedures, and the accompanying hardware and other paraphernalia that are brought or built into these units combine to create harsh, dehumanizing, and deprived conditions of confinement. These conditions

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[69] For example, see: Brock Bastian & Nick Haslam, *Excluded from Humanity: The Dehumanizing Effects of Social Ostracism*, 46 Journal of Experimental Social Psychology 107-113 (2010); Stephanie Cacioppo & John Cacioppo, *Decoding the Invisible Forces of Social Connections*, 6 Frontiers in Integrative Neuroscience 51 (2012); DeWall, et al., *Belongingness as a Core Personality Trait: How Social Exclusion Influences Social Functioning and Personality Expression*, 79 Journal of Personality 979-1012 (2011); Damiano Fiorillo & Fabio Sabatini, *Quality and Quantity: The Role of Social Interactions in Self-Reported Individual Health*, 73 Social Science & Medicine 1644-1652 (2011); S. Hafner et al., *Association Between Social Isolation and Inflammatory Markers in Depressed and Non-depressed Individuals: Results from the MONICA/KORA Study*, 25 Brain, Behavior, and Immunity 1701-1707 (2011); Johan Karremans, et al., *Secure Attachment Partners Attenuate Neural Responses to Social Exclusion: An fMRI Investigation*, 81 International Journal of Psychophysiology 44-50 (2011); Graham Thornicroft, *Social Deprivation and Rates of Treated Mental Disorder: Developing Statistical Models to Predict Psychiatric Service Utilisation*, 158 British Journal of Psychiatry 475-484 (1991).

predictably can impair the psychological functioning of the prisoners who are subjected to them.[70] For some prisoners, these impairments can be permanent and life-threatening.

168. For example, mental health and correctional staff who have worked in disciplinary segregation and isolation units have reported observing a range of problematic symptoms manifested by the prisoners confined in these places. The authors of one of the early studies of solitary confinement summarized their findings by concluding that "[e]xcessive deprivation of liberty, here defined as near complete confinement to the cell, results in deep emotional disturbances."[71]

169. A decade later, Professor Hans Toch's large-scale psychological study of prisoners "in crisis" in New York State correctional facilities

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[70] For example, see: Kristin Cloyes, David Lovell, David Allen & Lorna Rhodes, *Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample*, 33 Criminal Justice and Behavior 760-781 (2006); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, *supra* note 49; and Peter Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, Volume 34, Crime and Justice (Michael Tonry, ed.) (pp. 441-528), Chicago: University of Chicago Press (2006).

[71] Bruno M. Cormier & Paul J. Williams, *Excessive Deprivation of Liberty*, 11 Canadian Psychiatric Association Journal 470-484, 484 (1966). For other early studies of solitary confinement, see: Paul Gendreau, N. Freedman, G. Wilde, & George Scott, *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 Journal of Abnormal Psychology 54-59 (1972); George Scott & Paul Gendreau, *Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison*, 12 Canadian Psychiatric Association Journal 337-341 (1969); Richard H. Walters, John E. Callagan & Albert F. Newman, *Effect of Solitary Confinement on Prisoners*, 119 American Journal of Psychiatry 771-773 (1963).

included important observations about the effects of isolation.[72] After he and his colleagues had conducted numerous in-depth interviews of prisoners, Toch concluded that "isolation panic" was a serious problem in solitary confinement. The symptoms that Toch reported included rage, panic, loss of control and breakdowns, psychological regression, and a build-up of physiological and psychic tension that led to incidents of self-mutilation.[73] Professor Toch noted that although isolation panic could occur under other conditions of confinement, it was "most sharply prevalent in segregation." Moreover, it marked an important dichotomy for prisoners: the "distinction between imprisonment, which is tolerable, and isolation, which is not."[74]

170. More recent studies have identified other symptoms that appear to be produced by these conditions. Those symptoms include: appetite and sleep disturbances, anxiety, panic, rage, loss of control, paranoia, hallucinations, and self-mutilations. Moreover, direct studies of prison isolation have documented an extremely broad range of harmful

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[72] Hans Toch, *Men in Crisis: Human Breakdowns in Prisons*, Chicago: Aldine Publishing Co. (1975).

[73] *Id.* at 54.

[74] *Ibid.*

psychological reactions. These effects include increases in the following potentially damaging symptoms and problematic behaviors: anxiety, withdrawal, hypersensitivity, ruminations, cognitive dysfunction, hallucinations, loss of control, irritability, aggression, rage, paranoia, hopelessness, a sense of impending emotional breakdown, self-mutilation, and suicidal ideation and behavior.[75]

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[75] In addition to the numerous studies cited in the articles referenced *supra* at notes 61 and 67, there is a significant international literature on the adverse effects of solitary confinement. For example, see: Henri N. Barte, *L'Isolement Carceral*, 28 Perspectives Psychiatriques 252 (1989). Barte analyzed what he called the "psychopathogenic" effects of solitary confinement in French prisons and concluded that prisoners placed there for extended periods of time could become schizophrenic instead of receptive to social rehabilitation. He argued that the practice was unjustifiable, counterproductive, and "a denial of the bonds that unite humankind." In addition, see: Reto Volkart, *Einzelhaft: Eine Literaturubersicht* (Solitary confinement: A literature survey), 42 Psychologie - Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen 1-24 (1983) (reviewing the empirical and theoretical literature on the negative effects of solitary confinement); Reto Volkart, Adolf Dittrich, Thomas Rothenfluh & Paul Werner, *Eine Kontrollierte Untersuchung uber Psychopathologische Effekte der Einzelhaft* (A controlled investigation on psychopathological effects of solitary confinement), 42 Psychologie - Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen 25-46 (1983) (when prisoners in "normal" conditions of confinement were compared to those in solitary confinement, the latter were found to display considerably more psychopathological symptoms that included heightened feelings of anxiety, emotional hypersensitivity, ideas of persecution, and thought disorders); Reto Volkart, et al., *Einzelhaft als Risikofaktor fur Psychiatrische Hospitalisierung* (Solitary confinement as a risk for psychiatric hospitalization), 16 Psychiatria Clinica 365-377 (1983) (finding that prisoners who were hospitalized in a psychiatric clinic included a disproportionate number who had been kept in solitary confinement); Boguslaw Waligora, *Funkcjonowanie Czlowieka W Warunkach Izolacji Wieziennej* (How men function in conditions of penitentiary isolation), Seria Psychologia I Pedagogika NR 34, Poland (1974) (concluding that so-called "pejorative isolation" of the sort that occurs in prison strengthens "the asocial features in the criminal's personality thus becoming an essential cause of difficulties and failures in the process of his resocialization"). See also, Ida Koch, *Mental and Social Sequelae of Isolation: The Evidence of Deprivation Experiments and of Pretrial Detention in Denmark, in The Expansion of European Prison Systems*, Working Papers in European Criminology, No. 7, 119 (Bill Rolston &

171. In addition, we know that self-mutilation and suicide are more prevalent in isolated, punitive housing units such as administrative segregation and security housing units, where prisoners are subjected to solitary-like conditions of confinement. For example, clinical researchers Ray Patterson and Kerry Hughes attributed higher suicide rates in solitary confinement-type units to the heightened levels of "environmental stress" that are generated by the "isolation, punitive sanctions, [and] severely restricted living conditions" that exist there.[76] These authors reported that "the conditions of deprivation in locked units and higher-security housing were a common stressor shared by many of the prisoners who committed

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Mike Tomlinson, eds.) (1986) who found evidence of "acute isolation syndrome" among detainees that occurred after only a few days in isolation and included "problems of concentration, restlessness, failure of memory, sleeping problems and impaired sense of time and an ability to follow the rhythm of day and night" (at p. 124). If the isolated confinement persisted—"a few weeks" or more—there was the possibility that detainees would develop "chronic isolation syndrome," including intensified difficulties with memory and concentration, "inexplicable fatigue," a "distinct emotional lability" that can include "fits of rage," hallucinations, and the "extremely common" belief among isolated prisoners that "they have gone or are going mad" (at p. 125). See also: Michael Bauer, Stefan Priebe, Bettina Haring & Kerstin Adamczak, *Long-Term Mental Sequelae of Political Imprisonment in East Germany*, 181 Journal of Nervous & Mental Disease, 257-262 (1993), who reported on the serious and persistent psychiatric symptoms suffered by a group of former East German political prisoners who sought mental health treatment upon release and whose adverse conditions of confinement had included punitive isolation.

[76] Raymond Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation*, 1999-2004, 59 Psychiatric Services 676-682, 678 (2008).

suicide."[77] Similarly, a team of researchers in New York recently reported that "[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm after we controlled for the length of jail stay, SMI [whether the inmate was seriously mentally ill], age, and race/ethnicity."[78] In addition, signs of deteriorating mental and physical health (beyond self-injury), other-directed violence, such as stabbings, attacks on staff, and property destruction, and collective violence are also more prevalent in these units.[79]

172. The empirical consensus on the harmfulness of isolated or solitary-type confinement is very broad. I say that despite the fact that there

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[77] *Id.* See also, Lindsay M. Hayes, *National Study of Jail Suicides: Seven Years Later*, Special Issue: Jail Suicide: A Comprehensive Approach to a Continuing National Problem, 60 Psychiatric Quarterly, 7 (1989); Alison Liebling, *Vulnerability and Prison Suicide*, British Journal of Criminology, 36, 173-187 (1995); and Alison Liebling, *Prison Suicide and Prisoner Coping*, 26 Crime and Justice, 283-359 (1999).

[78] Fatos Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 American Journal of Public Health, 442-447, 445 (2014).

[79] For example, see: Howard Bidna, *Effects of Increased Security on Prison Violence*, 3 Journal of Criminal Justice 33-46 (1975); K. Anthony Edwards, *Some Characteristics of Prisoners Transferred from Prison to a State Mental Hospital*, 6 Behavioral Sciences and the Law 131-137 (1988); Elmer H. Johnson, *Felon Self-Mutilation: Correlate of Stress in Prison*, Jail House Blues (Bruce L. Danto, ed.), Michigan: Epic Publications (1973); Anne Jones, *Self-Mutilation in Prison: A Comparison of Mutilators and Nonmutilators*, 13 Criminal Justice and Behavior 286-296 (1986); Peter Kratcoski, *The Implications of Research Explaining Prison Violence and Disruption*, 52 Federal Probation 27-32 (1988); Ernest Otto Moore, *A Prison Environment: Its Effect on Health Care Utilization*, Dissertation Abstracts, Ann Arbor, Michigan (1980); Frank Porporino, *Managing Violent Individuals in Correctional Settings*, 1 Journal of Interpersonal Violence, 213-237 (1986); Pamela Steinke, *Using Situational Factors to Predict Types of Prison Violence*, 17 Journal of Offender Rehabilitation, 119-132 (1991).

is one study that has been cited for a different conclusion. The so-called "Colorado Study" of one year in "administrative segregation," is sometimes referenced as evidence that isolated confinement does not pose a significant risk to the psychological well-being of prisoners. However, the Colorado Study focused on a maximum of one year in administrative segregation, in contrast to many ADOC prisoners who report being retained in segregation for much longer periods, including some who are "closed out" (i.e., confined indefinitely on Segregation status) and others who do not know whether or how they will ever be released from such confinement. In addition, the conditions that existed in Colorado at the time that study was conducted there were far more benign than those I observed in the ADOC.

173. Moreover, there were very significant methodological errors made in the design of the Colorado Study that render its results impossible to interpret or generalize. Indeed, the Colorado Study has been roundly criticized by a number of researchers from a variety of disciplines (psychology, psychiatry, anthropology, history, and law) as deeply flawed. Many of these experts have published critiques of the study in which they conclude that its methodological problems are so severe as to render the

results uninterpretable.[80] These serious methodological problems led well-known prison researchers David Lovell and Hans Toch to note in their critique of the study that "[d]espite the volume of the data, no systematic interpretation of the findings is possible."[81] Many other published criticisms of the study's methodology reached similar conclusions.[82]

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[80] The serious methodological problems include: the inappropriate exposure of all groups to the key treatment variable (isolation); the continued cross-contamination of the general population and administrative segregation groups throughout the study (confounding the interpretation of any differences or similarities between them); the use of a convenience and patchwork sample rather than a representative group of participants; the failure to record (and, therefore, the inability to quantify or code) the exact nature of the conditions of confinement (especially, the amount or degree of isolation) to which each participant or group of participants was exposed; employing a single, inexperienced research assistant with only a bachelor's degree (who wore a badge identifying her to the prisoners as a department of corrections employee) to collect *all* of the study data; problematic instances in which the research assistant questioned the truthfulness of the prisoners' responses and required them to "redo" the tests being administered; the total reliance on self-reported rating scales that were created through the disaggregation and reconstruction/recombination of subscales taken from other test batteries that had not been validated with prisoner populations; and the failure to utilize even a basic interview with the study participants or to make use of the behavioral observational data that were collected (that appeared at odds with the prisoner self reports).

[81] David Lovell & Hans Toch, *Some Observations about the Colorado Segregation Study*, Correctional Mental Health Report, May/June 2011, 3-4, 14.

[82] For example, see: Stuart Grassian & Terry Kupers, *The Colorado Study Versus the Reality of Supermax Confinement*, Correctional Mental Health Report, May/June 2011, 1-4; Lorna A. Rhodes & David Lovell, *Is Adaptation the Right Question? Addressing the Larger Context of Administrative Segregation: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental Health, (June 21, 2011) 1-9, [available at: http://community.nicic.gov/cfs-file.ashx/__key/CommunityServer.Components.PostAttachments/00.00.05.95.19/Supermax-_2D00_-T-_2D00_-Rhodes-and-Lovell.pdf]; Sharon Shalev & Monica Lloyd, *If This Be Method, Yet There Is Madness in It: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental

174. Notwithstanding these critiques, and perhaps more importantly, two of the study's other authors, Jeffrey Metzner and Jamie Fellner, have published an article concluding that "[i]solation can be harmful to any prisoner," and that the potentially adverse effects of isolation include "anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis."[83] In fact, their deep concerns over the harmfulness of isolated conditions of confinement led them to recommend that professional organizations "should actively support practitioners who work for changed segregation policies and they should use their institutional authority to press for a nationwide rethinking of the use of isolation" in the name of their "commitment to ethics and human rights."[84]

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Health, (June 21, 2011) 1-7, [available at: http://community.nicic.gov/cfs-file.ashx/__key/CommunityServer.Components.PostAttachments/00.00.05.95.21/Supermax-_2D00_-T-_2D00_-Shalev-and-Lloyd.pdf]; and Peter Scharff Smith, *The Effects of Solitary Confinement: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental Health, (June 21, 2011) 1-11, [available at: http://community.nicic.gov/cfs-file.ashx/__key/CommunityServer.Components.PostAttachments/00.00.05.95.22/Supermax-_2D00_-T-_2D00_-Smith.pdf].

[83] Jeffrey Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,* 38 Journal of the Academy of Psychiatry and Law, 104-108 (2010) at p. 104, [available at: http://www.hrw.org/sites/default/files/related_material/Solitary%20Confinement%20and%20Mental%20Illness%20in%20US%20Prisons.pdf].

[84] *Id.* at p. 107. In addition, Maureen O'Keefe, a former researcher for the Colorado Department of Corrections and the primary author of the study, is on record as favoring

175. In any event, the painfulness and damaging potential effects of solitary confinement are underscored by the fact that it is commonly used in so-called "brainwashing" and certain forms of torture. In fact, many of the negative effects of solitary confinement are analogous to the acute reactions suffered by torture and trauma victims, including post-traumatic stress disorder ("PTSD") and the kind of psychiatric sequelae that plague victims of what are called "deprivation and constraint" torture techniques.[85]

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significant reductions in the use of prison isolation (or "administrative segregation" as it is known in Colorado). She is also very clear about what she termed a misuse or misinterpretation of the Study's results: "[W]e do not believe in any way and we do not promote the study as something to argue for the case of segregation… My interpretation is that people believe that this study sanctions administrative segregation for mentally ill and nonmentally ill alike… I do not believe that the conclusions lend to that and that is not the intended use of our study. Deposition of Maureen O'Keefe at 96, 101 (Oct. 25, 2013), Sardakowski v. Clements, No. 1:2012cv01326 (D. Colo. filed May 21, 2012) (Civil Action No. 12-CV-01326-RBJ-KLM). In addition to the serious methodological flaws that have been identified in the Colorado Study, and the positions that virtually all of its authors have taken acknowledging the harmful effects of isolation and opposing its use with mentally ill prisoners in particular, the Colorado Department of Corrections itself has moved over the last several years to both very significantly reduce the overall number of prisoners who are housed in isolation units (again, termed "administrative segregation" there). Memo to Wardens from Lou Archuleta, Interim Director of Prisons, Colorado DOC, December 10, 2013; see, also: Jennifer Brown, *Colorado Stops Putting Mentally Ill Prisoners in Solitary Confinement*, Denver Post, Dec. 12, 2013 [available at: http://www.denverpost.com/news/ci_24712664/colorado-wont-put-mentally-ill-prisoners-solitary-confinement].

[85] Solitary confinement is among the most frequently used psychological torture techniques. In D. Foster, *Detention & Torture in South Africa: Psychological, Legal & Historical Studies*, Cape Town: David Philip (1987), Psychologist Foster listed solitary confinement among the most common "psychological procedures" used to torture South African detainees (at p. 69), and concluded that "[g]iven the full context of dependency, helplessness and social isolation common to conditions of South African security law detention, there can be little doubt that solitary confinement under these circumstances should in itself be regarded as a form of torture" (at p. 136). See also: Matthew Lippman, *The Development and Drafting of the United Nations Convention Against Torture and*

176. The prevalence of the psychological symptoms suffered in solitary confinement—that is, the percentage of prisoners placed in these units who suffer from specific signs of psychological distress—is often very high. For example, in an early study that I conducted at the Security Housing Unit (SHU) at Pelican Bay State Prison in California, I did systematic assessments of a randomly selected sample of 100 prisoners who were housed there. The sample was randomly selected to ensure that it consisted of a representative group of SHU prisoners. The representativeness of the sample allowed me to estimate the prevalence of psychological trauma and isolation-related pathology among the population of Pelican Bay SHU prisoners. In fact, I found that every symptom of psychological distress that I measured but one (fainting spells) was suffered by more than half of the prisoners who were interviewed.[86] Many of the symptoms were reported by two-thirds or more of the prisoners assessed in this isolated housing unit, and some were suffered by nearly everyone. Well over half of the prisoners who were isolated in the Pelican Bay SHU

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*Other Cruel, Inhuman or Degrading Treatment or Punishment*, 27 Boston College International & Comparative Law Review, 275 (1994); Tim Shallice, *Solitary Confinement—A Torture Revived?* New Scientist (1974); F.E. Somnier & I.K. Genefke, *Psychotherapy for Victims of Torture*, 149 British Journal of Psychiatry 323-329 (1986); and Shaun R. Whittaker, *Counseling Torture Victims*, 16 The Counseling Psychologist 272-278 (1988).

[86] See Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, supra* note 61.

reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that are known to be stress-related.

177. I also found that almost all of the prisoners whom I evaluated in the SHU reported ruminations or intrusive thoughts, an oversensitivity to external stimuli, irrational anger and irritability, difficulties with attention and often with memory, and a tendency to socially withdraw. Almost as many prisoners reported a constellation of symptoms indicative of mood or emotional disorders—concerns over emotional flatness or losing the ability to feel, swings in emotional responding, and feelings of depression or sadness that did not go away. Finally, sizable minorities of the prisoners reported symptoms that are typically only associated with more extreme forms of psychopathology—hallucinations, perceptual distortions, and thoughts of suicide.

178. Although these specific symptoms of psychological stress and the psychopathological reactions to isolation are numerous and well-documented, and provide important indices of the risk of harm to which isolated prisoners are subjected, there are other significant aspects to the psychological pain and dysfunction that solitary confinement can produce, ones that extend beyond these specific and more easily measured symptoms and reactions. Depriving people of normal social contact and

meaningful social interaction over long periods of time can damage or distort their social identities, destabilize their sense of self and, for some, destroy their ability to function normally in free society.

179. Psychologists know that social contact is fundamental to establishing and maintaining emotional health and well-being. As one researcher put it: "Since its inception, the field of psychology emphasized the importance of social connections."[87] "Affiliation"—the opportunity to have meaningful contact with others—helps us reduce anxiety in the face of uncertainty or fear-arousing stimuli.[88] Indeed, one of the ways that people determine the appropriateness of their feelings—how we establish the very nature and tenor of our emotions—is through contact with others.[89]

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[87] C. DeWall, *Looking Back and Forward: Lessons Learned and Moving Forward*, The Oxford Handbook of Social Exclusion (C. DeWall, ed.) (pp. 301-303), New York: Oxford University Press (2013).

[88] For example, see: Stanley Schachter, *The Psychology of Affiliation: Experimental Studies of the Sources of Gregariousness*, Stanford, CA: Stanford University Press (1959); Irving Sarnoff & Philip Zimbardo, *Anxiety, Fear, and Social Affiliation*, 62 Journal of Abnormal Social Psychology 356-363 (1961); Philip Zimbardo & Robert Formica, *Emotional Comparison and Self-Esteem as Determinants of Affiliation*, 31 Journal of Personality 141-162 (1963).

[89] For example, see: A. Fischer, A. Manstead, & R. Zaalberg, *Social Influences on the Emotion Process*, European Review of Social Psychology, Volume 14 (M. Hewstone & W. Stroebe, eds.) (pp. 171-202), Wiley Press (2004); C. Saarni, *The Development of Emotional Competence,* New York: Guilford Press (1999); Stanley Schachter & Jerome Singer, *Cognitive, Social, and Physiological Determinants of Emotional State*, 69 Psychological Review 379-399 (1962); L. Tiedens & C. Leach (Eds.), *The Social Life of Emotions*, New York: Cambridge University Press (2004); S. Truax, *Determinants of Emotion Attributions: A Unifying View*, 8 Motivation and Emotion, 33-54 (1984).

Prolonged social deprivation is painful and destabilizing in part because it deprives persons of the opportunity to ground their thoughts and emotions in a meaningful social context—to know what they feel and whether those feelings are appropriate.

180. Not surprisingly then, numerous scientific studies have established the psychological significance of social contact, connectedness and belongingness. They have concluded, among other things, that the human brain is literally "wired to connect" to others.[90] Thwarting this "need to connect" not only undermines psychological well-being but also increases physical morbidity and mortality. Indeed, in part out of recognition of the importance of the human need for social contact, connection, and belongingness, social psychologists and others have written extensively about the harmful effects of its deprivation—what happens when people are subjected to social exclusion and isolation. Years ago, Herbert Kelman argued that denying persons of contact with others was a form of dehumanization.[91] More recently, others have documented

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[90] M. Lieberman, *Social: Why Our Brains Are Wired to Connect*, New York: Random House (2013).

[91] H. Kelman, *Violence Without Restraint: Reflections on the Dehumanization of Victims and Victimizers*, Varieties of Psychohistory (G. Kren & L. Rappaport, eds.) (pp. 282-314), New York: Springer (1976).

the ways in which social exclusion is not only "painful in itself," but also "undermines people's sense of belonging, control, self-esteem, and meaningfulness, reduces pro-social behavior, and impairs self-regulation."[92] Indeed, the subjective experience of social exclusion results in what has been called "cognitive deconstructive states" in which there is emotional numbing, reduced empathy, cognitive inflexibility, lethargy, and an absence of meaningful thought.[93]

181. In fact, the editor of an authoritative *Oxford Handbook of Social Exclusion* concluded the volume by summarizing the "serious threat" that social exclusion represents to psychological health and well-being, including "increased salivary cortisol levels… and blood flow to brain regions associated with physical pain," "sweeping changes" in attention, memory, thinking, and self-regulation, as well as changes in aggression and prosocial behavior. As he put it: "This dizzying array of responses to social exclusion supports the premise that it strikes at the core of well-being."[94]

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[92] Bastian & Haslam, *supra* note 69, at p. 107, internal references omitted.

[93] J. Twenge, K Catanese, & R. Baumeister, *Social Exclusion and the Deconstructed State: Time Perception, Meaninglessness, Lethargy, Lack of Emotion, and Self Awareness*. 85 Journal of Personality and Social Psychology 409-423 (2003).

[94] DeWall, *supra* note 87, at p. 302.

182. In a broader sense, the social deprivation and social exclusion imposed by solitary confinement engenders *social pathology*—necessary adaptations that prisoners must make to live in an environment that is devoid of normal social contact—that is, to exist and function in the absence of meaningful interaction and closeness with others. In this socially pathological environment, prisoners have no choice but to adapt in socially pathological ways. Over time, they gradually change their patterns of thinking, acting and feeling to cope with the profoundly asocial world in which they are forced to live, accommodating to the absence of social support and the routine feedback that comes from normal, meaningful social contact.

183. There are several problematic features to the social pathologies that isolated prisoners are forced to adopt. The first is that, although these adaptations are functional—even *necessary*—under the isolated conditions in which they live, the fact that prisoners eventually "adjust" to the absence of others does not mean that the experience ceases to be painful. Some prisoners have told me that the absence of meaningful contact and the loss of closeness with others are akin to a dull ache or pain that never goes away. Others remain acutely aware of the relationships that have ended and the feelings that can never be rekindled.

184. Second, some prisoners cope with the painful, asocial nature of their isolated existence by paradoxically creating even more distance between themselves and others. For some, the absence of others becomes so painful that they convince themselves that they do not need social contact of any kind—that people are a "nuisance" after all, and the less contact they have the better. As a result, they socially withdraw further from the world around them, receding even more deeply into themselves than the sheer physical isolation of solitary confinement and its attendant procedures require. Others move from initially being starved for social contact to eventually being disoriented and even frightened by it. As they become increasingly unfamiliar and uncomfortable with social interaction, they are further alienated from others and made anxious in their presence.[95]

185. Third, and finally, while these social pathological adaptations are functional and even necessary in the short-term, over time they tend to be internalized and persist long after the prisoner's time in isolation has ended. Thus, the adaptations move from being consciously employed

[95] For evidence that solitary confinement may lead to a withdrawal from social contact or an increased tendency to find the presence of people increasingly aversive or anxiety arousing, see: B. Cormier & Williams, supra note 71; Haney, *supra* note 61; H. Miller & G. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 Criminal Behaviour and Mental Health 85-94 (1997); Scott & Gendreau, *supra* note 71; Toch, *supra* note 49; and Waligora, *supra* note 75.

survival strategies or noticeable reactions to immediate conditions of confinement to becoming more deeply ingrained ways of being. Prisoners may develop extreme habits, tendencies, perspectives, and beliefs that are difficult or impossible to relinquish once they are released. Although their adaptations may have been functional in isolation (or appeared to be so), they are typically acutely dysfunctional in the social world most prisoners are expected to re-enter. In extreme cases, these ways of being are not only dysfunctional but have been internalized so deeply that they become disabling, interfering with the capacity to live a remotely normal or fulfilling social life. In this way, long-term isolation can make prisoners' adjustment to general population especially painful and challenging, particularly if the prison administration does not meaningfully assist them in re-socialization.

186. It is also important to note that, although social deprivation is the source of the greatest psychological pain that prisoners experience in solitary confinement and places them at the greatest risk of harm, Segregation Units like those operated by the ADOC deprive prisoners of many other things as well. These units operate by imposing high levels of

repressive control, enforce almost complete idleness or inactivity,[96] reduce positive environmental stimulation to a bare minimum,[97] and impose physical and material deprivations that collectively produce psychological distress and can exacerbate the negative consequences of social deprivation. Indeed, most of the things that we know are actually beneficial to prisoners—such as increased participation in institutional programming, contact visits with persons from outside the prison, opportunities for meaningful physical exercise or recreation, and so on[98]—are either

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[96] For example, we know that people in general require a certain level of mental and physical activity in order to remain mentally and physically healthy. Simply put, human beings need movement and exercise to maintain normal functioning. The severe restrictions that are imposed in isolation units—typically no more than an hour or so a day out of their cells—can negatively impact prisoners' well-being. Denying prisoners access to normal and necessary human activity places them at risk of psychological harm.

[97] Many of them experience a form of sensory deprivation or "reduced environmental stimulation"—there is an unvarying sameness to the physical stimuli that surround them. These prisoners exist within the same limited spaces and are subjected to the same repetitive routines, day in and day out. There is little or no external variation to the experiences they are permitted to have or can create for themselves. They not only see and experience the same extremely limited physical environment, but also have minimal, routinized, and superficial contacts with the same very small group of people, again and again, for years on end. This loss of perceptual and cognitive or mental stimulation may result in the atrophy of important skills and capacities. For examples of this range of symptoms, see: Brodsky & Scogin, *Inmates in Protective Custody: First Data on Emotional Effects*, 1 Forensic Reports, 267-280 (1988); S. Grassian, *Psychopathological Effects of Solitary Confinement*, 140 American Journal of Psychiatry 1450-54 (1983); Haney, *supra* note 61; Miller & Young, *supra* note 95; and Volkart, et al., *supra* note 75.

[98] J. Wooldredge, *Inmate Experiences and Psychological Well-Being*, 26 Criminal Justice and Behavior 235-250 (1999).

functionally denied or greatly restricted for prisoners who are housed in Segregation Units. Thus, in addition to the social pathology that is created by the experience of solitary confinement, these other stressors also can produce additional negative psychological effects.

187. In addition, conditions of solitary confinement in most prison isolation units deprive prisoners of the opportunity to give and receive caring human touch. Many of the prisoners in these units go for months or years without ever touching another person with affection. Yet, psychologists have long known that: "Touch is central to human social life. It is the most developed sensory modality at birth, and it contributes to cognitive, brain, and socioemotional development throughout infancy and childhood."[99] The need for caring human touch is so fundamental that early deprivation is a risk factor for neurodevelopmental disorders, depression, suicidality, and other self-destructive behavior.[100] Later deprivation is

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[99] M. Hertenstein, D. Keltner, B. App, B. Bulleit & A. Jaskolka, *Touch Communicates Distinct Emotions*, 6 Emotion 528-533, 528 (2006). See, also: M. Hertenstein & S. Weiss (Eds.), *The Handbook of Touch: Neuroscience, Behavioral, and Health Perspectives*, New York: Springer (2011).

[100] For example, see: C. Cascio, *Somatosensory Processes in Neurodevelopmental Disorders*, 2 Journal of Neurodevelopmental Disorders 62-69 (2010); S. Field, *Touch Deprivation and Aggression Against Self Among Adolescents*, Developmental Psychobiology of Aggression (D. Stoff & E. Susman, eds.) (117-140), New York: Cambridge (2005).

associated with violent behavior in adolescents.[101] Conversely, a number of experts have argued that caring human touch is so integral to our well being that it is actually therapeutic; it has been recommended to treat a host of maladies including depression, suicidality, and learning disabilities.[102]

188. Not every prisoner housed in segregation will suffer all of these adverse psychological reactions. However, the nature and magnitude of the negative psychological reactions that I have documented in my own research and that have been reported by others in the literature underscore the stressfulness and painfulness of this kind of confinement, the lengths to

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[101] T. Field, *Violence and Touch Deprivation in Adolescents*, 37 Adolescence 735-749 (2002). Recent theory and research now indicate that "touch is a primary platform for the development of secure attachments and cooperative relationships," is "intimately involved in patterns of caregiving," is a "powerful means by which individuals reduce the suffering of others," and also "promotes cooperation and reciprocal altruism." J. Goetz, D. Keltner & E. Simon-Thomas, *Compassion: An Evolutionary Analysis and Empirical Review*, 136 Psychological Bulletin 351-374, 360 (2010). The uniquely prosocial emotion of compassion "is universally signaled through touch," so that persons who live in a world without touch are denied the experience of receiving or expressing compassion in this way. J. Stellar & D. Keltner, *Compassion*, Handbook of Positive Emotions ( M. Tugade, M. Shiota & L. Kirby, eds.) (pp. 329-341), New York: Guilford (2014). Researchers have found that caring human touch mediates a sense of security and place, a sense of shared companionship, of being and nurturing, feelings of worth and competence, access to reliable alliance and assistance, and guidance and support in stressful situations. R. Weiss, *The Attachment Bond in Childhood and Adulthood*, Attachment Across the Life Cycle (C. Parkes, J. Stevenson-Hinde, & P. Marris, eds.) (pp. 66-76), London: Routledge (1995).

[102] For example, see: S. Dobson, S. Upadhyaya, I. Conyers & R. Raghavan, *Touch in the Care of People with Profound and Complex Needs*, 6 Journal of Learning Disabilities, 351-362 (2002); T. Field, *Deprivation and Aggression Against Self Among Adolescents*. Developmental Psychobiology of Aggression (D. Stoff & E. Susma, eds.) (pp. 117-140), New York: Cambridge (2005).

which prisoners must go to adapt and adjust to it, and the risk of harm that it creates. The potentially devastating effects of these conditions are reflected in the characteristically high numbers of suicide deaths, and incidents of self-harm and self-mutilation that occur in many of these units.

189. The years of sustained research on solitary confinement, the negative outcomes that have been documented across time and locality, and the theoretical consistency of these findings with what is known more generally in the psychological literature about the harmful effects of isolation leave little doubt about its negative effects. These effects are not only painful but can do real harm and inflict real damage that is sometimes severe and can be irreversible. Indeed, for some prisoners, the attempt to cope with isolated confinement sets in motion a set of cognitive, emotional, and behavioral changes that are long-lasting. They can persist beyond the time that prisoners are housed in isolation and lead to long-term disability and dysfunction.

190. Thus, the accumulated weight of the scientific evidence that I have cited and summarized above documents and confirms that isolated confinement can produce a range of adverse psychological effects. We clearly do know what happens to people in prison and elsewhere in society when they are deprived of normal social contact for extended periods of

time. The evidence I have summarized above describes and details the risk of psychological harm that long-term isolation creates, including mental pain and suffering and the increased incidence of self-harm and suicide. In recent years, new insights about the fundamental human need for meaningful social contact and for caring human touch have added theoretical dimensions to the already existing substantial body of empirical data on these issues. These new insights add considerable weight to the long-standing consensus view: the experience of solitary confinement is not only painful but also places prisoners at significant risk of serious psychological harm.

B. *A Shifting Correctional Consensus on the Painful and Harmful Effects of Isolated Confinement*

191. In addition to the increasingly broad and deep scientific consensus on the painfulness and harmfulness of isolated confinement, a number of state correctional systems have explicitly recognized the psychological risks as well as the added expense and overall ineffectiveness of punitive isolation and taken steps to significantly reduce its use. A recent New York Times Magazine article is instructive on this issue as well. It reported the current views of Colorado officials, including the head of its Department of Corrections: "Gov. John W. Hickenlooper of Colorado signed [a bill banning solitary confinement for anyone under 21] at the

urging of the state corrections chief, Rick Raemisch, who spent a night in solitary confinement and wrote about it in a New York Times Op-Ed. concluding that its overuse is 'counterproductive and inhumane.'"[103]

192. In fact, over the last several years, prison systems as diverse as Maine and Mississippi have drastically reduced the number of prisoners housed in solitary or isolated confinement.[104] In addition, several states have closed their primary solitary confinement units altogether. For example, in January, 2013, the Illinois Department of Corrections closed its supermax prison located at the Tamms Correctional Center.[105] In Colorado, in addition to reducing their administrative segregation population by

[103] M. Binelli, *This Place is Not Designed for Humanity*, New York Times Magazine (March 29, 2015), p. 40. For the Colorado Executive Director of Corrections Op Ed, see R. Raemisch, *My Night in Solitary*, New York Times (February 20, 2014) [available at: http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html?_r=0].

[104] For a discussion of the nature and impact of the reforms to punitive isolation in Mississippi, see T. Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Alternative Mental Health Programs*, 36 Criminal Justice & Behavior 1037 (2009); and J. Buntin, *Exodus: How America's Reddest State—And Its Most Notorious Prison—Became a Model of Corrections Reform*, 23 Governing, 20 (2010). For a discussion of the nature of the reforms to punitive isolation in Maine, see: Z. Heiden, *Change Is Possible: A Case Study of Solitary Confinement Reform in Maine*, ACLU of Maine, (March 2013) [available at: http://www.aclumaine.org/sites/default/files/uploads/users/admin/ACLU_Solitary_Report_webversion.pdf]; and Tapley, L., Reform Comes to the Supermax, Portland Phoenix, May 25, 2011 [available at: http://portland.thephoenix.com/news/121171-reform-comes-to-the-supermax/].

[105] See Illinois Department of Corrections, Tamms Correctional Center Closing—Fact Sheet, [available at: http://www.ilga.gov/commission.cgfa2006/upload/TammsMeetingTestimonyDocuments.pdf.]

nearly 37%, the Department of Corrections completely shut down a 316-bed Administrative Segregation facility.[106]

193. Finally, the Vera Institute of Justice recently received funding from Department of Justice to launch a Safe Alternatives to Segregation Initiative ("SAFE Initiative") with the explicit goal of assisting states and counties to reduce their use of segregation and solitary confinement and to develop effective alternatives to its use. The 11-member Vera SAFE Initiative Advisory Board (of which I am a member) includes several state corrections secretaries and deputy secretaries, including those in Colorado, New Mexico, Pennsylvania, and Washington, who are publicly committed to developing ways of achieving significant reductions in the use of prison isolation.

### C. *Additional Legal and Human Rights Standards Addressing the Painful and Harmful Effects of Isolated Confinement*

194. In large part in response to the scientific evidence that I have summarized above, and out of the recognition that meaningful social contact and interaction is central to psychological health and well-being, the American Bar Association and virtually every major human rights and

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[106] News Release, Department of Corrections, The Department of Corrections Announces the Closure of Colorado State Penitentiary II (March 19, 2012) [available at: http://www.doc.state.co.us/sites/default/files/Press%20release%20CSP%20II%20close%20%20Feb%201%202013.pdf].

mental health organization in the United States as well as internationally have taken public stands in favor of significantly limiting solitary or isolated confinement use (if not abandoning it altogether). These organizations include major legal, medical, and health organizations, as well as faith communities and international monitoring bodies.

195. For example, the United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment concluded that solitary confinement for longer than 15 days constitutes torture, and that juveniles and people with mental illness should never be held in solitary confinement.[107] The American Academy of Child and Adolescent Psychiatry issued a statement opposing "the use of solitary confinement in correctional facilities for juveniles," stating that "any youth that is confined for more than 24 hours must be evaluated by a mental health professional," and aligning AACAP with the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, which includes among "disciplinary measures constituting cruel, inhuman or degrading treatment" "closed or solitary confinement or any other punishment that

[107] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc A/66/268, ¶¶ 76-78 (Aug. 5, 2011).

may compromise the physical or mental health of the juvenile concerned."[108] American Public Health Association issued a statement in which it detailed the public-health harms posed by solitary confinement, urged correctional authorities to "eliminate solitary confinement for security purposes unless no other less restrictive option is available to

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[108] American Academy of Child and Adolescent Psychiatry, *Solitary Confinement of Juvenile Offenders* (2012) [available at: http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx]. Calls for the prohibition of the use of isolated confinement for vulnerable populations such as juveniles underscore the widespread recognition that it is a psychologically painful and potentially very harmful environment. The same message is conveyed by the numerous calls to significantly limit the duration of solitary confinement or to eliminate its use altogether with prisoners who are mentally ill. For example, see, e.g., American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012), [available at: http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf] ("Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates."); Mental Health America, *Seclusion and Restraints, Policy Position Statement 24* (2011), [available at: http://www.nmha.org/positions/seclusion-restraints] ("urg[ing] abolition of the use of seclusion… to control symptoms of mental illnesses"); National Alliance on Mental Illness, *Public Policy Platform Section 9.8*, [available at: http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38253] ("oppos[ing] the use of solitary confinement and equivalent forms of extended administrative segregation for persons with mental illnesses"); Society of Correctional Physicians, *Position Statement, Restricted Housing of Mentally Ill Inmates* (2013), [available at: http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates] ("acknowledg[ing] that prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment," and recommending against holding these prisoners in segregated housing for more than four weeks).

manage a current, serious, and ongoing threat to the safety of others," and recommended that "[p]unitive segregation should be eliminated."[109]

196. Various faith-based organizations have issued similar policy statements and recommendations urging significant reductions in the use of solitary confinement and its outright elimination for some populations. For example, New York State Council of Churches passed a resolution in 2012 opposing the use of prison isolation and urging all members of the faith to participate in work to "significantly limit the use of solitary confinement."[110] Similarly, that same year, the Rabbinical Assembly called on prison authorities to end prolonged solitary confinement and the solitary confinement of juveniles and of people with mental illness.[111]

197. In fact, in recognition of the adverse mental health effects of segregated, solitary, or isolated confinement, the American Bar

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[109] American Public Health Association, *Solitary Confinement as a Public Health Issue*, Policy No. 201310 (2013), [available at: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1462.

[110] New York State Council of Churches, *Resolution Opposing the Use of Prolonged Solitary Confinement in the Correctional Facilities of New York State and New York City* (2012), [available at: https://sites.google.com/site/nyscouncilofchurches/priorities/on-solitary-confinement]; Presbyterian Church (USA), *Commissioners' Resolution 11-2, On Prolonged Solitary Confinement in U.S. Prisons* (2012), [available at: https://pc-biz.org/MeetingPapers/(S(em2ohnl5h5sdehz2rjteqxtn))/Explorer.aspx?id=4389].

[111] Rabbinical Assembly, *Resolution on Prison Conditions and Prisoner Isolation* (2012), [available at: http://www.rabbinicalassembly.org/story/resolution-prison-conditions-and-prisoner-isolation?tp=377].

Association's Standards for Criminal Justice on the Treatment of Prisoners mandate that "[s]egregated housing should be for the briefest term and under the least restrictive conditions practicable."[112] Moreover, the ABA requires that the mental health of all prisoners in segregated housing "should be monitored" through a process that should include daily correctional staff logs "documenting prisoners' behavior," the presence of a "qualified mental health professional" inside each segregated housing unit "[s]everal times a week," weekly observations and conversations between isolated prisoners and qualified mental health professionals, and "[a]t least every [90 days], a qualified mental health professional should perform a comprehensive mental health assessment of each prisoner in segregated housing" (unless such assessment is specifically deemed unnecessary in light of prior individualized observations).[113] In addition, at intervals "not to exceed [30 days], correctional authorities should meet and document an evaluation of each prisoner's progress" in an evaluation that explicitly "should also consider the nature of the prisoner's mental health," and at

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[112] American Bar Association, *ABA Criminal Justice Standards on the Treatment of Prisoners, Standard 23-2.6(a)* (2010), [available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html [hereinafter "ABA Standards"].

[113] ABA Standards, 23-2.8(b).

intervals "not to exceed [90 days], a full classification review" should be conducted that addresses the prisoner's "individualized plan" in segregation with "a presumption in favor of removing the prisoner from segregated housing."[114]

198. Moreover, just last year, the United Nations Crime Commission approved the Standard Minimum Rules for the Treatment of Prisoners (known as the "Mandela Rules") that contained several provisions designed to significantly regulate and limit the use of solitary confinement. Specifically, Rule 43.1 prohibits the use of "indefinite" and "prolonged" solitary confinement, as well as the placement of prisoners in dark or constantly lit cells."[115] More generally, Rule 45.1 provides that solitary confinement "shall be used only in exceptional cases as a last resort, for as short a time as possible…" and Rule 45.2 prohibits its use entirely "in the

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[114] ABA Standards, 23-2.9. See, also: New York Bar Association, *Committee on Civil Rights Report to the House of Delegates: Solitary Confinement in New York State 1-2 Resolution* (2013), [available at: http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26699], which called on state officials to significantly limit the use of solitary confinement, and recommended that solitary confinement for longer than 15 days be proscribed.

[115] Commission on Crime Prevention and Criminal Justice, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules),* United Nations Economic and Social Council (May 21, 2015). The Commission defined "solitary confinement" as "confinement of prisoners for 22 hours or more a day without meaningful human contact." See Rule 44.

case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[116]

199. Finally, in addition to prominent human rights, mental health, and legal organizations, distinguished expert panels that have investigated and analyzed these issues have reached similar conclusions. For example, in 2006, a landmark report was published that was based in large part on a series of fact-finding hearings conducted across the United States by the bipartisan Commission on Safety and Abuse in America's Prisons. In the course of the hearings, diverse groups of nationally recognized experts, stakeholders, and policymakers testified about a wide range of prison-related issues. Among other things, the Commission concluded that solitary confinement was "expensive and soul destroying"[117] and recommended that prison systems "end conditions of isolation."[118]

200. The next year, in 2007, an international group of prominent mental health and correctional experts meeting on psychological trauma in

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[116] *Ibid.*

[117] John Gibbons and Nicholas Katzenbach, *Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons,* p. 59, New York: Vera Institute of Justice (2006) [available at: http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf].

[118] *Id.* at p. 57.

Istanbul, Turkey issued a joint statement on "the use and effects of solitary confinement." In what has come to be known as the "Istanbul Statement," they acknowledged that the "central harmful feature" of solitary confinement is its reduction of meaningful social contact to a level "insufficient to sustain health and well being."[119] Citing various statements, comments, and principles that had been previously issued by the United Nations—all recommending that the use of solitary confinement be carefully restricted or abolished altogether—the Istanbul group concluded that "[a]s a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort." Notably, the specific recommendations they made about how such a regime should be structured and operated would, if adopted, end most forms of long-term isolated confinement.

201. And, most recently—in April 2016— the National Commission on Correctional Health Care ("NCCHC") issued a Position Statement on solitary confinement.[120] Relying on many of the sources and consensus positions that I have quoted in the preceding paragraphs of this section of

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[119] International Psychological Trauma Symposium, *Istanbul Statement on the Use and Effects of Solitary Confinement*. Istanbul, Turkey (December 9, 2007), [available at: http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf

[120] [Available at: http://www.ncchc.org/solitary-confinement].

my Report, the NCCHC declared, among other things, that solitary confinement of longer than 15 days constitutes "cruel, inhumane, or degrading treatment of inmates" of the sort that correctional health professionals should not participate in. Specifically, the NCCHC Position Statement included the provision that juveniles, mentally ill individuals, and pregnant women should be "excluded from solitary confinement of any duration" (emphasis added), and that health care staff should advocate to correctional officials that solitary confinement never exceed 15 days continuous duration, and also advocate to them that they should bar juveniles and mentally ill prisoners entirely from such confinement.

202. Based on the observations and interviews that I conducted in the Alabama prison system, it is my opinion that the ADOC and MHM are jointly or separately in clear violation of the letter and/or the spirit of literally every one of the 17 "principles" pertaining to solitary confinement that the NCCHC declared in its recent Position Statement.

203. In summary, the conclusion that long-term solitary or isolated confinement subjects prisoners to grave risk of serious psychological harm continues to be theoretically sound, has widespread and growing empirical support, and now reflects the overwhelming consensus view of human

rights, mental health, and legal organizations as well as expert groups that have carefully considered the issue.

D. *Consensus on Limiting to Very Brief Exposure, Only After a Showing of Absolute Need or Necessity, and the Exclusion of Vulnerable Populations*

204. It is worth emphasizing that the widespread recognition of the painful and harmful mental and physical effects of prison isolation that I have summarized above has led to a consensus about three critically important limits that must be applied to such confinement: 1) the time or duration that a person is exposed to solitary confinement must be kept to an absolute minimum, 2) the risks of harm are so great that solitary confinement should be used only when it is absolutely necessary and as a last resort, and 3) the added risk of harm to vulnerable groups or individual prisoners means that they should be exempted entirely from prolonged solitary confinement.

205. Thus, virtually every mental health, legal, and human rights standard and set of recommendations concerning solitary confinement acknowledges that the risk of harm from isolation is time- or dose-dependent—that is, because the risks of psychological and physical damage increase as a function of the increased length of exposure, the use of solitary confinement should be limited to the briefest amount of time

possible. In addition to those organizations that call for an outright ban on the use of solitary confinement because of its recognized harmful effects, below is a summary of just some of the recommendations that have been issued on time limits—limits that are typically measured in days and weeks (not many months or even many years, as is the case in the ADOC):

—The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment wrote in 2011 that in his opinion solitary confinement lasting more than 15 days can constitute "torture;"[121]

—The American Bar Association's 2010 Standards for Criminal Justice hold that "[s]egregated housing should be for the briefest term and under the least restrictive conditions practicable"[122] and that at intervals "not to exceed [90 days], a full classification review" should be conducted that addresses the prisoner's "individualized plan" in

[121] Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc A/66/268, ¶¶ 76-78 (Aug. 5, 2011).

[122] American Bar Association, *ABA Criminal Justice Standards on the Treatment of Prisoners, Standard 23-2.6(a)* (2010), [available at: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html] [hereinafter "ABA Standards"].

segregation with "a presumption in favor of removing the prisoner from segregated housing;"[123]

—The prominent mental health and correctional experts meeting on psychological trauma in 2007 in Istanbul, Turkey who issued the "Istanbul Statement" concluded that "[a]s a general principle solitary confinement should only be used… for as short a time as possible;"[124]

— The American Academy of Child and Adolescent Psychiatry's 2012 policy statement on the solitary confinement of juveniles states that "any youth that is confined for more than 24 hours must be evaluated by a mental health professional;"[125]

—The New York Bar Association in 2013 called on state officials to significantly limit the use of solitary confinement and recommended that solitary confinement for longer than 15 days be proscribed;[126]

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[123] ABA Standards, 23-2.9 (emphases added).

[124] International Psychological Trauma Symposium, *Istanbul Statement on the Use and Effects of Solitary Confinement*, Istanbul, Turkey (December 9, 2007), [available at: http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf].

[125] American Academy of Child and Adolescent Psychiatry, *Solitary Confinement of Juvenile Offenders* (2012) (emphasis added), [available at: http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx].

[126] New York Bar Association, *Committee on Civil Rights Report to the House of Delegates: Solitary Confinement in New York State 1-2 Resolution* (2013), [available at: http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26699]. See also, The

— The Society of Correctional Physicians concluded that segregating mentally ill prisoners on a "prolonged" basis lasting for more than four weeks should be prohibited;[127]

—The American Psychiatric Association (APA) recommended in 2012 that "prolonged segregation" (which it defined as segregation lasting longer than four weeks) of prisoners with serious mental illness "with rare exceptions, should be avoided due to the potential for harm to such prisoners;"[128]

— And the United Nations Commission on Crime Prevention and Criminal Justice's Standard Minimum Rules for the Treatment of Prisoners passed just last year defined "prolonged solitary confinement" as lasting "for a time period in excess of 15 consecutive

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Rabbinical Assembly, *Resolution on Prison Conditions and Prisoner Isolation* (2012), [available at: http://www.rabbinicalassembly.org/story/resolution-prison-conditions-and-prisoner-isolation?tp=377, which called on prison authorities to end prolonged solitary confinement.

[127] Society of Correctional Physicians, *Position Statement, Restricted Housing of Mentally Ill Inmates* (2013), [available at: http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates].

[128] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012), [available at: http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf].

days," and mandated that such prolonged confinement "shall be prohibited."[129]

206. Many of these same organizations and agencies similarly emphasized that the grave risk of serious harm from solitary confinement require that it be used only upon a showing of absolute necessity. For example, the authors of the "Istanbul Statement" concluded that "[a]s a general principle solitary confinement should only be used in very exceptional cases… and only as a last resort,"[130] and the United Nations used almost identical language in formulating the "Mandela Rules" for the Treatment of Prisoners, mandating that solitary confinement "shall be used only in exceptional cases as a last resort."[131]

207. Moreover, expert, legal, and human rights organizations also have recommended that, because of the increased grave risk of serious harm to which solitary confinement exposes them, vulnerable prisoners

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[129] See Commission on Crime Prevention and Criminal Justice, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*, United Nations Economic and Social Council (May 21, 2015) Rule 43.1 and Rule 44.

[130] International Psychological Trauma Symposium, *Istanbul Statement on the Use and Effects of Solitary Confinement*. Istanbul, Turkey (December 9, 2007), [available at: http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf].

[131] Commission on Crime Prevention and Criminal Justice, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules),* United Nations Economic and Social Council (May 21, 2015) Rule 45.1.

(such as juveniles and the mentally ill) should be exempted from any form of prolonged placement. Thus, as I noted earlier, the American Psychiatric Association (APA) has recommended that "prolonged segregation" of prisoners with serious mental illness "with rare exceptions, should be avoided due to the potential for harm to such inmates,"[132] and United Nations Standard Minimum Rules for the Treatment of Prisoners, Rule 45.2, prohibits its use entirely "in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[133]

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[132] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012), [available at: http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf].

[133] See Commission on Crime Prevention and Criminal Justice, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules),* United Nations Economic and Social Council (May 21, 2015), Rule 45.2. See, also: American Academy of Child and Adolescent Psychiatry, *Solitary Confinement of Juvenile Offenders* (2012), [available at http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx], which opposes "the use of solitary confinement in correctional facilities for juveniles"; Mental Health America, *Seclusion and Restraints, Policy Position Statement,* 24 (2011), [available at: http://www.nmha.org/positions/seclusion-restraints,] "urg[ing] abolition of the use of seclusion . . . to control symptoms of mental illnesses"; and the National Alliance on Mental Illness, *Public Policy Platform Section 9.8,* [available at: http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38253, "oppos[ing] the use of solitary confinement and equivalent forms of extended administrative segregation for persons with mental illnesses."

208. As I will discuss in the remainder of this Report, all three of these consensus positions are regularly violated in the ADOC. Prisoners are kept in isolated confinement for very long periods of time, substantially longer than many of the tolerable or acceptable maximum limits envisioned in any of the guidelines or principles that have been promulgated. Moreover, many prisoners are kept there despite long periods of conforming behavior and their continued isolation is hardly "necessary" to achieve any legitimate penological goal or interest. And, finally, again, as I will discuss below, the cumulative effects of the long lengths of time spent in isolation by mentally ill prisoners in the ADOC, during which time they absorb significant adverse psychological stressors and pains, continue to take a serious toll on them. The truly extreme and degrading nature of the conditions in the ADOC Segregation Units and the heightened vulnerability of this population represent compelling arguments in favor of completely ending or at least drastically reducing this practice to conform to the professional, legal, and human rights standards cited above.

### E. *The Exacerbating Effects of Segregated Confinement on Mental Illness*

209. Finally, by way of emphasis, there are very sound theoretical reasons that explain why prisoners who suffer from serious mental illness have a much more difficult time tolerating the painful experience of

isolation or solitary confinement. In part, it is simply because of the greater vulnerability of the mentally ill in general to stressful, traumatic conditions. In addition, some of the extraordinary conditions of isolation adversely impact the particular symptoms from which mentally ill prisoners suffer (such as depression) or directly aggravate aspects of their pre-existing psychiatric conditions.

210. Although prison isolation places all prisoners at serious risk of harm, its adverse psychological effects are expected to vary as a function not only of the specific nature and duration of the isolation (such that more deprived conditions experienced for longer amounts of time are likely to have more detrimental consequences) but also as a function of the characteristics of the prisoners subjected to it. A rare and unusually resilient prisoner might be able to withstand even harsh forms of solitary confinement with few or minor adverse effects, especially if the experience does not last for an extended period of time. Conversely, some prisoners are especially vulnerable to the psychological pain and pressure of solitary confinement, and deteriorate even after brief exposure. Mentally ill prisoners are particularly at risk in these isolated environments and have been precluded from them by legal and human rights mandates precisely because of this. There are several reasons why this is so.

211. For one, as I have noted, under the kind of solitary or isolated confinement to which the ADOC regularly subjects prisoners, they endure significantly more stress and psychological pain than under other forms of imprisonment. Mentally ill prisoners are generally more sensitive and reactive to psychological stressors and emotional pain. In many ways, the harshness and severe levels of deprivation that are imposed on them in isolation are the antithesis of the kind of benign and socially supportive atmosphere that mental health clinicians seek to create within genuinely therapeutic environments. Not surprisingly, mentally ill prisoners are more likely to deteriorate and decompensate when they are subjected to the harshness and stress of prison isolation.

212. Some of the deterioration and decompensation that mentally ill prisoners suffer in isolated confinement results from the critically important role that social contact and social interaction play in maintaining psychological equilibrium. The esteemed psychiatrist Harry Stack Sullivan once summarized the clinical significance of meaningful social contact by observing that "[w]e can't be alone in things and be very clear on what happened to us, and we... can't be alone and be very clear even on what is happening in us very long—excepting that it gets simpler and simpler, and

more primitive and more primitive, and less and less socially acceptable."[134] Social contact and social interaction are essential components in the creation and maintenance of normal social identity and social reality.

213. Thus, the experience of isolation is psychologically destabilizing as it undermines a person's sense of self or social identity and erodes his connection to a shared social reality. Isolated prisoners have few if any opportunities to receive feedback about their feelings and beliefs, which become increasingly untethered from any normal social context. As Cooke and Goldstein put it:

> A socially isolated individual who has few, and/or superficial contacts with family, peers, and community cannot benefit from social comparison. Thus, these individuals have no mechanism to evaluate their own beliefs and actions in terms of reasonableness or acceptability within the broader community. They are apt to confuse reality with their idiosyncratic beliefs and fantasies and likely to act upon such fantasies, including violent ones.[135]

In extreme cases, a related pattern emerges: isolated confinement becomes so painful, so bizarre, and so impossible to make sense of that some

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[134] Harry Stack Sullivan,*The Illusion of Personal Individuality*, 12 Psychiatry 317-332 (1971), at p. 326.

[135] Compare, also, Margaret K. Cooke & Jeffrey H. Goldstein, *Social Isolation and Violent Behavior*, 2 Forensic Reports287-294 (1989), at p. 288.

prisoners create their own reality—they live in a world of fantasy instead of the intolerable one that surrounds them.

214. Finally, many of the direct negative psychological effects of isolation mimic or parallel specific symptoms of mental illness. Even though the direct effects of isolation, experienced in reaction to adverse conditions of confinement, are generally less chronic than those that are produced by a diagnosable mental illness, they can add to and compound a mentally ill prisoner's outward manifestation of symptoms as well as the internal experience of their disorder. For example, many studies have documented the degree to which isolated confinement contributes to feelings of lethargy, hopelessness, and depression. For already clinically depressed prisoners, these acute situational effects are likely to exacerbate their pre-existing chronic condition and lead to worsening of their depressed state. Similarly, the mood swings that some prisoners report experiencing in isolation would be expected to amplify the pre-existing emotional instability that prisoners diagnosed with bi-polar disorder suffer. Prisoners who suffer from disorders of impulse control would likely find their pre-existing condition made worse by the frustration, irritability, and anger that many isolated prisoners report experiencing. And prisoners prone to psychotic breaks may suffer more in isolated confinement due to

conditions that deny them the stabilizing influence of social feedback that grounds their sense of reality in a stable and meaningful social world.

215. As I noted in passing above, widespread recognition of the heightened vulnerability of mentally ill prisoners to the adverse psychological effects of isolated confinement has led numerous corrections officials, professional mental health groups, and human rights organizations to prohibit their placement in such units or, if it is absolutely necessary (and only as a last resort) to confine them there, to very strictly limit the duration of such confinement, and to provide prisoners with significant amounts of out-of-cell time and augmented access to care. For example, the American Psychiatric Association ("APA") has issued a Position Statement on Segregation of Prisoners with Mental Illness stating:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space an adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for the individuals.[136]

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[136] AM. PSYCH. ASSOC., *POSITION STATEMENTS: SEGREGATION OF PRISONERS WITH MENTAL ILLNESS* (2012), available at [http://www.psychiatry.org/advocacy--newsroom/position-statements].

The APA's position on this issue reflects the accepted fact that mentally ill prisoners are especially vulnerable to isolation- and stress-related regression, deterioration, and decompensation that worsen their psychiatric conditions and intensify their mental health-related symptoms and maladies (including depression, psychosis, and self-harm).

216. This widely accepted fact about the heightened vulnerability of mentally ill prisoners to isolated confinement is acknowledged in the standard operating procedures that govern their admission and retention in such units. Specifically, mental health staff in most prison systems with which I am familiar are charged with the responsibility of screening prisoners in advance of their possible placement in isolation to identify those who are mentally ill and to exclude them from such confinement. Moreover, they are charged with the additional responsibility of regularly monitoring isolated prisoners with the same intended purpose—to identify any prisoners who may be manifesting the signs and symptoms of emerging mentally illness and to remove them from these harmful environments.

217. Courts that have been presented with evidence on this issue have reached the same conclusions about the vulnerability of the mentally ill to severe forms of prison isolation. One such court noted that those prisoners for whom the psychological risks of isolated confinement were

"particularly"—and unacceptably—high included anyone suffering from "overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness as a result of the conditions in [solitary confinement]."[137] The judge elaborated, noting that the group of prisoners to be excluded from isolation should include:

> [T]he already mentally ill, as well as persons with borderline personality disorders, brain damage or mental retardation, impulse-ridden personalities, or a history of prior psychiatric problems or chronic depression. For these inmates, placing them in [isolated confinement] is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk is high enough, and the consequences serious enough, that we have no hesitancy in finding that the risk is plainly "unreasonable."[138]

218. In sum, the accumulated weight of the scientific evidence that I have cited and summarized above demonstrates the painful nature of solitary confinement, and the serious risk of significant psychological harm at which it places prisoners in general and mentally ill prisoners in particular. When persons are deprived of normal social contact for extended periods of time they experience mental pain and suffering, are more susceptible to severe stress-related maladies and disorders, are subject to deterioration and dysfunction along a number of mental,

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[137] *Madrid v. Gomez*, 889 F.Supp. 1146, at 1265 (N.D. Cal. 1995).

[138] Id.

emotional, and physical dimensions, and are placed at risk of even more serious harm, including the loss of their sanity and even their lives. The broad range of adverse effects that derive from social deprivation underscores the fundamental importance of meaningful social contact and interaction and, in essence, establishes these things as identifiable human needs.

219. Over the long-term, meaningful social contact and interaction may be as essential to a person's psychological well-being as adequate food, clothing, and shelter are to his or her physical well-being. This appears to be true for prisoners in general, but it is especially true for mentally ill prisoners who are particularly vulnerable to the pains of isolated confinement and susceptible to its harmful effects.

220. Yet very large numbers of seriously mentally ill prisoners continue to languish for very long periods of time in extremely harsh ADOC Segregation units that are located in correctional facilities all over the state. These prisoners, especially, absorb significant amounts of adverse psychological stress and pain, which not only take a serious psychological toll on them but also place them at risk of much greater deterioration. The adverse psychological consequences can be severe, long-lasting, even permanent and, in the case of the many mentally ill prisoners for whom the

risk of suicide is intensified in isolation, fatal. These are compelling reasons to completely end or at least drastically reduce the ADOC's widespread practice of placing mentally ill prisoners in Segregation, to conform to the professional, legal, and human rights standards that I have cited above.

## VII. Systemic Dysfunction in the ADOC

221. In the preceding two sections of this report, I have tried to put what I believe are key structural problems that plague the ADOC—especially, the chronic high levels of overcrowding (and associated problems of understaffing) and the resulting widespread use of harmful forms of segregation (especially for mentally ill prisoners)—in a larger context, by explaining what is known scientifically about how these conditions and practices can do real harm to individual prisoners and undermine the operation of prison systems more broadly. My narratives in the Appendix (Ex. 4) detailing the widespread maltreatment of prisoners and the profound neglect of their fundamental mental health needs that I witnessed and documented throughout ADOC can and should be understood in this larger context.

225. In this section of my Report, I turn to a remaining, overarching issue—the truly systemic nature of the serious dysfunction that I identified in the ADOC, and the evidence that I saw indicating not only that these

problems are deep-seated and long-standing, but also that they are getting worse rather than better.

226. I have already noted in passing that the observations that I made about various ADOC facilities were remarkably consistent throughout my tours—that is, with only minor variations, virtually the same kinds of problems surfaced in each of the facilities that I inspected. Moreover, there was remarkable consistency in what prisoner after prisoner in these separate facilities told me (as documented in Appendix, Ex. 4). It did not seem to matter whether the prisoners I interviewed were selected randomly for brief cell-front interviews, selected for individual, confidential interviews after having been seen cell-front, picked randomly from the facility's prisoner roster for individual confidential interviews, or suggested by counsel for Plaintiffs—they all told essentially the same kind of grim and often tragic stories. In addition, because many of them had been housed in other ADOC facilities, they were in a position to confirm that the problems—the mistreatment and neglect—that they were encountering at their present facility were not unique to that place but rather existed in facilities throughout the ADOC.

227. In addition, these consistent accounts, and my own broad conclusions about systemic deficiencies throughout the Alabama prison

system, are corroborated in many important respects by the candid observations and conclusions reached by an entirely different group of people—namely, mental health officials (employed by the third-party contract provider mental health provider MHM) charged with system-wide oversight responsibilities and the provision of mental health services in Alabama's 15 major prisons. Their stated opinions provide strong support for my own observations about the system-wide magnitude of the very serious problems that I encountered.

228. The problems with the delivery of mental health services throughout the ADOC start with the issue of mental health screening. As of February 2016, the mental health caseload in the Alabama prison system was 14.2% of the prison population, with 9.7% on psychotropic medications.[139] In addition, the ADOC has identified just 1.3% of their prisoner population as suffering anything more than a "mild impairment" as a result of their mental condition.[140] These numbers are reason for concern. They suggest that MHM is significantly under-identifying the prevalence of mental illness in the prisoner population, drastically under-

[139] According to the MHM Monthly Report, February, 2016.

[140] According to the MHM Monthly Report, February, 2016.

counting the number of prisoners who suffer from and need appropriate treatment for this disability.

229. I can provide some context for this assertion. In 2000, the American Psychiatric Association estimated that as many as one in five prisoners, or 20%, was seriously mentally ill.[141] The most recent Bureau of Justice Statistics report found that 56% of state prisoners nationally suffered from "mental health problems" (either having been recently given a clinical diagnosis or received treatment or suffered from DSM IV symptoms of a mental disorder). This included nearly a quarter who were suffering with major depression and one in six (15.4%) with symptoms of psychosis.[142] In California, the state that has most recently litigated the issue of the role that overcrowding plays in causing states to deliver constitutionally inadequate mental health care, the percentage of the prisoner population that is on the mental health caseload is above 30%.[143] The current ADOC figure of less than 15% of the prisoner population on the

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[141] American Psychiatric Association, *Psychiatric Services in Jails and Prisons*, 2nd Ed. (Washington D.C., American Psychiatric Association, 2000), introduction, p. XIX.

[142] D. James & L. Glaze, *Mental Health Problems of Prison and Jail Inmates*. September, 6, 2006. Bureau of Justice Statistics Special Report. NCJ 213600. Washington, DC: U.S. Department of Justice.

[143] California Department of Corrections and Rehabilitation Reports Monthly Archive; Coleman Monthly Reports (HC-POP-and MIS) for January 2016.

mental health caseload overall, and only 1.3% who are more than "mildly impaired," is thus almost certainly a gross underestimate of the true needs of this vulnerable population. It makes the failure to deliver necessary and adequate mental health care to a misleadingly small number of identified prisoner/patients all the more problematic and indefensible.

230. This likely gross underestimate of the number of mentally ill prisoners in the system and the failure to deliver necessary and adequate mental health care to mentally ill prisoners in the Alabama prison system begins with systemic problems in the screening and ongoing monitoring of their mental health. Dr. Robert Hunter, who has served as Chief Psychiatrist and Medical Director for MHM in Alabama since 2003, has acknowledged the difficult challenge of assessing mental illness in prisoners as they come into the prison system: "many patients with serious mental illness minimize their symptoms. They tell us at intake no, I'm not in mental health; no, I've never been on medication."[144] He also noted that there is a disincentive for prisoners to self-identify as mentally ill later on: "there's a stigma; and in prison mental patients can be preyed on, perhaps

[144] Deposition of Dr. Robert Hunter, April 21, 2016, at p. 51. (Hereafter, "Hunter Deposition.")

for their meds."[145] Yet the ADOC and MHM do little or nothing to proactively assess the mental health status of prisoners who were not placed on the mental health caseload at intake.

231. Similarly Brenda Fields, the Clinical Operations Associate for MHM who is responsible for conducting audits for all of MHM's operations nationally, acknowledged that MHM has never looked systematically at whether the mental health screening is "working well" in Alabama.[146] She conceded also that the information that is collected and relied upon during the intake process is incomplete. Ms. Fields noted further that "the nurse uses the information that she has, which is somewhat limited," in part by the fact that "the inmate[s] don't always tell you with an officer standing there."[147] I agree, and would only add that this problem—the lack of candor about mental health issues "with an officer standing there"—plagues nearly all of MHM's contact with prisoners throughout the Alabama prison

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[145] Hunter Deposition p. 60.

[146] Brenda Fields Deposition, February 5, 2016, at p. 204. (Hereafter, "Fields Deposition.") Teresa Houser, Program Director for MHM in Alabama confirmed that no tracking was done to determine whether the screening process is identifying all incoming mentally ill prisoners. She also noted that there is no additional mental health screening when prisoners transfer from one ADOC facility to another. Deposition of Teresa Houser, November 20, 2015, at p. 80, 83. (Hereafter, "Houser November Deposition.")

[147] Fields Deposition at p. 206.

system, including even during group therapy sessions and in many (if not most) individual counseling sessions (on the rare occasions that either of these things take place anywhere in the system).

232. But overcrowding and understaffing plague all subsequent aspects of the mental health delivery system, or what now passes as such in the ADOC. There are chronic and widespread problems with respect to insufficient correctional officer training on mental health issues and the existence of what might be called a "culture of harm" (rather than a culture of care) that approximates outright disdain for prisoners, especially mentally ill prisoners, in many facilities, placing the physical as well as psychological well-being of prisoners throughout the system in jeopardy.[148] Thus, corroborating what prisoners told me and that I reported earlier in this Report, Dr. Hunter acknowledged that he has heard reports that security staff make jokes about suicide to prisoners,[149] including "reports of someone suggesting an inmate follow through" with a threat to harm

[148] For a discussion of the elements of a "culture of harm" and some of the ways that they can be created inside a prison environment, see Craig Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 Criminal Justice and Behavior, 956-984 (2008).

[149] Hunter Deposition at 141-142.

himself,[150] and "not only of staff sort of egging the inmate on to do it, but actually providing him with a razor."[151]

233. Dr. Hunter elaborated further that he knew of "five, five to eight, maybe ten" instances over the past year in which custody staff have challenged prisoners to make good on their threats of self-harm—either "called their bluffs" or explicitly ignored their stated intentions to engage in self-harm and sent them back to their housing unit—and the prisoners in fact engaged in self-harm[152] including instances where the prisoner "was sent back to their housing unit only for them to perhaps act out in a more severe manner, such as cut deeper."[153] He also expressed concerns over "the razor issue and the widespread availability of razors" throughout the ADOC and, as I noted above, reported that not only have "staff sort of egg[ed] the inmate on to do it [commit suicide], but actually provid[ed] him with a razor" (although he fortunately characterized this scenario as "very, very infrequent").[154] Indeed, this serious problem was widespread enough that

[150] Hunter Deposition at p. 144.

[151] Hunter Deposition at p. 146.

[152] Hunter Deposition at pp. 163-165.

[153] Hunter Deposition at p. 165.

[154] Hunter Deposition at p. 146.

Dr. Hunter told staff explicitly: "We can no longer call an inmate's bluff to prove they are suicidal; we can't manage them that way now. Treat all suicidal threats seriously."[155] He acknowledged further that: "There has been the occasion that we have, in essence, called an inmate's bluff based on the information given at the time. And we've not put them on watch."[156]

234. Teresa Houser, Program Director for MHM also said that she was aware of "difficulties with ADOC personnel not informing MHM personnel promptly of people engaging in . . . self harm" at Holman,[157] including one instance in which the prisoner may have died partially as a result of MHM not being informed by custody staff.[158]

235. Moreover, some of the failure of staff to respond appropriately to the needs of mentally ill prisoners in the ADOC have occurred in the very places that are supposedly treatment-oriented facilities. Thus, Dr. Hunter observed that "there have been some concerns from our Bullock staff that certain individuals with DOC were less than cooperative in regards to some

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[155] Hunter Deposition at pp. 149-150. The statement was made at an April 22, 2015 MHM quarterly CQI meeting. MHM 031222.

[156] Hunter Deposition at pp. 151-152.

[157] Houser November Deposition at p. 256.

[158] Houser November Deposition at p. 257.

treatment issues."[159] Ironically, as he noted: "[T]here were certain folks who were dismissive of mental health, even though this is the mental health unit…"[160] Thus, although Bullock is ostensibly the ADOC's "treatment hub," it is also the case that "many security staff were conceptualizing it as a seg unit as opposed to a mental health unit. Part of that problem may have been because seg inmates were housed there. We have some concern about some of the folks working that unit not being adequately trained to work with mental health inmates."[161] Of course, this is troublesome and dangerous in the extreme. If security staff are "dismissive of mental health," cannot "conceptualize" the difference between a Seg unit and a mental health unit, and are not "adequately trained to work with mental patients" at the ADOC's treatment hub, where the most acutely mentally ill and vulnerable prisoners are housed, it is hard to imagine where in the system they would be functioning properly.

236. I would add only that the problems of staff at a treatment facility "not being adequately trained to work with mental health inmates," and of "security staff conceptualizing [a treatment facility] as an ad seg unit

[159] Hunter Deposition at p. 312.

[160] Hunter Deposition at p. 313.

[161] Hunter Deposition at p. 315.

rather than a mental health unit," as Dr. Hunter put it, are greatly exacerbated by the fact that the Stabilization units do, in fact, look and operate more as Segregation Units than treatment units. And, as I have pointed out, the very same thing can be said about the Stabilization Unit at Tutwiler, and the RTUs at ADOC's other main supposedly "treatment-oriented" facility, Donaldson.

237. Unfortunately, there are many other systemic problems that plague the ADOC, harming prisoners and preventing the delivery of necessary and appropriate mental health services. For example, one of the ways that overcrowding has undermined the functioning of the ADOC in general and its mental health care in particular is by contributing to a significant shortage of appropriate treatment space. Chronic overcrowding means that ADOC facilities manage more prisoners than they were designed to hold, and space that otherwise might be used for treatment is allocated to other needs. Available treatment space is taxed beyond its limits by the sheer numbers of prisoner/patients whose needs must be addressed.

238. I encountered this problem throughout the ADOC—in the form of inappropriate segregation-like units functioning as supposed "Residential Treatment Units," desperately mentally ill prisoners

languishing in seemingly uninhabitable "Stabilization Units" or filthy and degraded segregation units instead of being transferred elsewhere, the absence of functional group programming spaces in units that were supposed to be dedicated to treatment, individual counseling sessions that took place in open hallways, and administrative offices doubling as "Suicide Watch" or observation cells, and on and on. Even when appropriate space does exist, such as in the "Blue Building" at Bullock, it is inexplicably underused (perhaps because of the overcrowding-related problem of understaffing, that I will discuss at length below).

239. The systemic nature of the space-related problems that undermine and impede the delivery of mental health services that I saw in the ADOC facilities I toured and inspected were corroborated by opinions and observations voiced by MHM officials. Dr. Hunter opined at length about "a backlog on folks who need SU beds, who need RTU beds" in the ADOC and acknowledged that "[w]e've got a waiting list now."[162] He, too, conceded that there was problem with Stabilization Units functioning as Segregation Units, just as I had observed: "We've always had a problem with our treatment units, our stabilization units, doubling as a segregation

[162] Hunter Deposition at p. 158.

unit. And we've been clear and vocal that that's not the best use of our crisis space, and it does compromise treatment."[163]

240. I commented earlier and at some length about the very problematic Stabilization Units that I saw at several facilities, and suggested that they were inappropriate placements for the seriously mentally ill prisoners I found in them. MHM Program Director Teresa Houser acknowledged a related set of problems—that, for example, the ADOC uses the Stabilization Units at Bullock for "overflow seg," a practice that she noted causes problems "with security," with "programming," and "with the yard."[164] As she observed, the Bullock SU is rarely full just with patients who are in need of stabilization but also "often full with SU and seg overflow."[165] Of course, when it is full—which she said happens "often"—then the prisoners who need stabilization cells will "go on a waiting list" and remain at risk until they can be moved.[166] In a later deposition, Ms. Houser summarized the overall trend: "The SU and RTU were built for mental health services, and over time, while the mental health services were

[163] Hunter Deposition at p. 159 (emphasis added).

[164] Houser November Deposition at pp. 191-192.

[165] Houser November Deposition at p. 193 (emphasis added).

[166] Houser November Deposition at p. 193.

being provided, the SU was actually turning more in to a seg-type placement rather than a Stabilization Unit."[167]

241. ADOC's space-related shortages are multi-faceted and endemic in its overcrowded and under-resourced system, and the lack of appropriate treatment space in one area essentially reverberates through the system to affect another. Dr. Hunter appeared to recognize this as well, noting that, to date, MHM had only been able to take "baby steps" to address these issues by, for example, trying "to move some of those seg inmates out of the unit, move some of those inmates who are in the RTU elsewhere."[168] He went on to acknowledge a host of other problems, including the fact that MHM and ADOC are "up against . . . some tough issues with space and capacity and too many needs for crisis beds and not enough places to put these folks to deal with them."[169] He also noted that waiting lists have had to be created and discharges from SUs to RTUs delayed "because we didn't have the places to put them… [in] RTU beds at Donaldson."[170]

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[167] Deposition of Teresa Houser, April 22, 2016, at pp. 59-60. (Hereafter, "Houser April Deposition.")

[168] Hunter Deposition at p. 160.

[169] Hunter Deposition at pp. 160-161.

[170] Hunter Deposition at pp. 161-162.

242. Although there is an equal or greater problem with respect to staffing shortages in the ADOC (that I will discuss at length below), Dr. Hunter correctly observed that merely adding additional mental health personnel would not address the space issues, even though "we could definitely benefit from more staff to handle our increasing caseload." Yet, Dr. Hunter recognized that more staff would not "translate into less crises, less crisis placement"[171] as long as the system continued to lack appropriate spaces in which to put critically mentally ill prisoners.

243. Among other things, "not having enough crisis cells" has resulted in, by Dr. Hunter's account (and my own observation), putting suicidal prisoners into shift offices,[172] keeping them in Segregation (not Crisis) cells that only had a "more direct line of sight for the officers,"[173]

[171] Hunter Deposition at p. 162.

[172] Hunter Deposition at pp. 166-167.

[173] Hunter Deposition at p. 167. Apparently when Dr. Hunter informed the Warden at Bibb that he could not continue with that practice, the Warden said, "I got to do what I got to do" (as reported to Hunter by CQI manager Davis-Walker, at p. 168). It was unclear whether the Warden was going to continue the practice—continuing "to do what I got to do"—or expressed frustration at not being able to continue doing it (at 170).

using the library as a substitute for crisis cells,[174] and housing these seriously mentally ill prisoners in inappropriate medical cells.[175]

244. In addition to placing suicidal prisoners in makeshift "crisis" beds, space shortages have resulted in retaining Segregation prisoners in space that is supposedly designed for therapy (which I saw, in numerous places in the system, where Stabilization Units were used to house Segregation prisoners and a "time out" room inside a treatment area was used for long-term segregated confinement). These practices create a host of separate, additional problems. As Dr. Hunter put it, "segregation inmates' presence contaminat[es] the treatment milieu"[176] and he expressed concerns that mental health staff may not have adequate "autonomy" in the ADOC to modify or correct this systemic problem.[177]

245. MHM Program Director Houser similarly noted that at one facility "inmates were housed in the RTU that should not be there."[178] She reported that ADOC said the prisoners were inappropriately placed in the

[174] Hunter Deposition at p. 173.

[175] Hunter Deposition at p. 176.

[176] Hunter Deposition at p. 208.

[177] Hunter Deposition at pp. 208-210.

[178] Houser November Deposition at p. 74.

RTU "because they didn't have anywhere else to put them."[179] Ms. Houser described the practice as "a revolving door,"[180] noting that it has been an ongoing issue "for some years," and that it affects the ability to hold groups in the RTU.[181] She said that, although the seriousness of the problem fluctuates from time to time, it has not gotten better.[182]

246. Here, too, these very severe space problems are not limited to a few institutions. For example, according to Ms. Houser, clinical office space is inadequate at all facilities except Bullock and Tutwiler. This shortage includes a lack of rooms to conduct counseling sessions.[183] She noted that it also is difficult to conduct groups at Donaldson—the location of one of ADOC's maximum security RTUs for men—"because there is no space . . . except in an open-bay area. So there's no privacy. That's a big

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[179] Houser November Deposition at p. 74.

[180] Houser November Deposition at p. 75.

[181] Houser November Deposition at p. 76. Although she did not explain exactly why, I assume that it stems from the problems that can arise when inmates are housed in units that are inappropriate to their security or mental health status or classification in the prison system and are brought into close proximity with one another in group settings. Having prisoners who cannot or should not comingle, or cannot participate in group activities, limits the kinds of programming that can occur in the unit.

[182] Houser November Deposition at p. 77.

[183] Houser April Deposition at p. 279.

hindrance."[184] She, too, acknowledged having conveyed her concern to ADOC that Donaldson "doesn't have group space."[185] Based on what I saw at Donaldson in March 2016, there has been no effort to address the shortage.

247. In addition to the lack of appropriate space, the breakdown of mental health services in the ADOC is in part related to the woeful understaffing that plagues the system. According to the ADOC's own calculations, the documented staffing shortages throughout the Alabama prison system are truly staggering. The most recent data available for my review—the Monthly Statistical Report for March 2016[186]—indicates that the overall "Departmental Staffing" for correctional officers is 57.8% of authorized positions for close custody facilities, 42% for medium custody facilities, and 68.1% for the minimum custody facilities. By way of specific examples that focus pointedly on the implications of these significant staffing shortfalls for the ADOC's most seriously mentally ill prisoners, consider that the some of the very worst staffing problems occur at the three ADOC facilities that are supposedly dedicated to mental health

[184] Houser April Deposition at p. 280.

[185] Houser April Deposition at p. 281.

[186] Available at: [http://doc.alabama.gov/docs/MonthlyRpts/2016-03.pdf].

treatment. Specifically: Bullock's correctional officer staffing level is only 43% of its authorized positions, Donaldson's is 67.4% of its allocated positions, and Tutwiler's is 46.9%. These hard and troubling numbers provide some context for the comments and concerns expressed below.

248. The very severe staffing problems manifest themselves in a variety of ways and they have been clearly identified by MHM officials. For example, MHM Clinical Operations Associate Brenda Fields acknowledged that "officer shortages" meant they "had to kind of compromise"[187] in what they were able to do in mental health. In my opinion, based on my observations and interviews, "compromise" is a far too generous euphemism. At the large Donaldson Correctional Facility, for example, the staffing problem resulted in the termination of certain forms mental health treatment, as Ms. Fields herself acknowledged: "There were problems with not having enough officers, so a lot of the groups and programming were cancelled because of that . . . Biggest thing was just delivering the programming that's recommended or that's required under the policy."[188]

249. To take another example, Program Director Houser said that understaffing issues plague the RTUs in ways that are "very similar to the

[187] Fields Deposition at p. 56.

[188] Fields Deposition at p. 128.

ones of the SU, in that there might be times when there weren't enough officers."[189] She apparently has repeatedly asked for increased staffing but, as of the date of her deposition, had not gotten it.[190] At a later deposition, she went on to say that the problem of lack of groups at Fountain because of security staff shortages[191] is not limited to that facility; it instead happens "frequently" at St. Clair, Fountain, Holman, Bibb, and Donaldson.[192] She acknowledged further that these shortages adversely affect a wide variety of other of inter-related mental health services that are supposed to be provided—including "activity tech groups, individual counseling, seeing the providers, psychiatrist or nurse practitioner"—and causes segregation rounds to be "often delayed."[193]

250. Ms. Houser indicated further that staff shortages led to the disruption of mental health services "regularly" at St. Clair, Bibb, and Holman.[194] She elaborated in particular with respect to Donaldson, a

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[189] Houser November Deposition at p. 74.

[190] Houser November Deposition at pp. 80-82.

[191] Houser April Deposition at p. 187.

[192] Houser April Deposition at p. 190.

[193] Houser April Deposition at pp. 192-193.

[194] Houser April Deposition at p. 194.

facility that houses one of the ADOC's supposedly "therapeutic" environments: Donaldson "is a difficult facility to provide mental health services in at this time,"[195] because the combination of officer shortages and officers working in the facility who do not understand the needs of the prisoners "can create just a lack of a therapeutic milieus, and that, in and of itself, will cause problems."[196] As I noted earlier, the "lack of a therapeutic milieu" in a facility that is one of the only treatment facilities in the entire system is hardly, as Ms. Fields characterized it, a "compromise."

251. The staff shortages go beyond having an inadequate number of correctional officers (the effects of which I believe Eldon Vail is better positioned to more fully address than I), but extend also to mental health staffing. Dr. Hunter noted in his April 21, 2016 deposition that the mental health caseload in the ADOC has increased over the years and that it is now "starting to tax our ability to adequately do what we do…" Despite having "more inmates to deal with," he noted that MHM had not had "much in the way of any increase in staffing."[197] In fact, he said that mental health caseloads have grown from 60 to 80 or 90 patients per counselor and "[a]t

[195] Houser April Deposition at p. 206.

[196] Houser April Deposition at pp. 206-207.

[197] Hunter Deposition at p. 44.

some places, some MHPs are seeing triple digit caseloads"—which, if true, would represent a caseload increase of nearly 100 percent (from 60 to over a hundred). Moreover, as he noted, "[a] good number of these folks are on medication, thus they have to be seen by the provider."[198] In addition to the increase in sheer numbers, he identified another trend: the fact that MHM mental health staff is "seeing more acutely ill inmates" in Alabama prisons,[199] which makes the shortages of mental health staff all the more problematic.

252. Mental health staff shortages create other kinds of deficiencies in the delivery of mental health care, including ones that were recently identified in a facility audit of Donaldson, ostensibly one of the ADOC's treatment-oriented facilities. As Ms. Fields described the deficiencies there: "there's a shortage of mental health staff; admission nursing assessments to the RTU were not being completed; treatment plans were not being completed, not individualized… They were not always signed by the inmate

[198] Hunter Deposition at p. 45. MHM uses "provider" to include only psychiatrists and nurse practitioners, not psychologists. Id. at 47-48.

[199] Hunter Deposition at p. 50.

and the treatment team members. I questioned whether or not treatment team[s] were actually happening as a team and a team approach."[200]

253. As I have noted throughout this Report, the overcrowding-related problems and the deficiencies that exist in the delivery of mental health care in the ADOC are connected to another very serious structural deficiency in the way that the Alabama prison system currently manages prisoners—through its heavy reliance on extremely problematic Segregation Units and the practice of confining large numbers of mentally ill prisoners inside them—in deprived and isolated conditions of confinement that are not only singularly unsuited but dangerous for them to live in. Especially given the nature of the degraded and degrading conditions that prevail in these units, the practice is, in my opinion, badly misguided, destructive, and cruel.

254. This problem, too, is clearly a systemic one, and not limited to a few facilities or to one or another especially bad Segregation Unit. I found throughout my tours that this problematic practice of housing mentally ill prisoners in Segregation is consistently employed, and prisoner after prisoner manifested the harmful effects of being confined in these terrible units. On this issue as well, there is corroboration from MHM officials.

[200] Fields Deposition at p. 127.

Although they apparently are not in a position to directly influence ADOC policy on its segregation policies, they certainly recognize and have acknowledged in official documents and deposition testimony the psychological risks that the Alabama prison system is taking with its prisoners (and their patients) by placing so many of them there.

255. For example, Dr. Hunter described the nature and psychological impact of Segregation quite well, noting that "the overall environment in seg with—while on the one hand you have sensory deprivation, sometimes you can have sensory overload with other inmates yelling, banging, screaming, taunting; lack of appropriate stimulation. Those are just some general thoughts about that."[201] He conceded that "in general, segregation is potentially detrimental to one's health and well-being,"[202] and offered the opinion that "some changes would be good" in the way ADOC handles segregation, including that it be used more sparingly, and also "more in the way of, perhaps, alternative disciplinary strategies, I think the mentally ill should be given particular consideration for alternative sentencing, alternative adjudication of their issues."[203]

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[201] Hunter Deposition at p. 179.

[202] Hunter Deposition at p. 180.

[203] Hunter Deposition at p. 181.

256. Dr. Hunter also thoughtfully noted that the ADOC should not have people "accumulate seg time where it looks like an insurmountable mountain to climb."[204] His views on this kind of long-term segregation are shared not only be me but also virtually all of the experts who work on these issues (many of whose views I summarized in Section VI of this Report): "I mean, two weeks or a month is one thing, but repeated offenses oftentimes you get more and more seg time tack on and just bury yourself in there, and that can lead to a lot of helplessness, hopelessness, and despair."[205] As he says, these things have "been well written about, well published."[206] In fact, Dr. Hunter noted that he and representatives of MHM apparently met with the ADOC in October, 2015, to share their concerns about segregation, including "the deleterious effects of long-term seg placement, [and had] some discussion about what other systems are doing in that regard to address their problem." He reported that the commissioner's representative, ADOC Chief of Staff Steve Brown, expressed

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[204] Hunter Deposition at p. 181.

[205] Hunter Deposition at p. 181-2.

[206] Hunter Deposition at p. 182.

the sentiment that the commissioner "very much would like some reform on how seg is handled here in Alabama."[207]

257. Apparently, one of the things that precipitated this meeting was the increasing number of suicides over the last several years in the ADOC.[208] The potential connection between the rising suicide rate and ADOC's Segregation policies, and MHM's awareness of this relationship, was apparent. As Dr. Hunter put it: "in looking at the suicides on record for that period of time, again a common denominator in most of them was segregation placement or the prospect of segregation placement."[209] However, as of the date of Dr. Hunter's deposition, nothing had been done "to address mental health implications of segregation" since the October meeting,[210] and no follow up meeting between ADOC and MHM on this issue had occurred, even though the parties agreed to have one.[211]

258. The discussion of increased suicidality in the ADOC, its potential connection to Segregation policies, and MHM's response to both

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[207] Hunter Deposition at pp. 185, 188-191.

[208] Hunter Deposition at pp. 186-188.

[209] Hunter Deposition at p. 191.

[210] Hunter Deposition at p. 191.

[211] Hunter Deposition at p. 201.

issues underscores another systemic problem that compromises the delivery of mental health care in Alabama's prisons. It is that, on the one hand, MHM appears to be very much aware of a significant set of issues that compromise their effective delivery of mental health services (in ways that, as in the case of the role of segregation in increased suicidality, may jeopardize not only the psychological well-being but the lives of their individual prisoner/patients). On the other hand, however, they have failed to take meaningful steps to systematically address these issues.

259. Thus, for example, I do not believe that the Segregation Units I observed are fit environments in which to house the mentally ill (and some of them are not fit environments for anyone). However, in light of the conditions that characterize these places, and the substantial risks that segregated confinement poses for everyone, but especially for the mentally ill—risks of which MHM is well aware—the policies and practices they follow to protect the health and well-being of the prisoner/patients in these units are woefully deficient.

300. By way of example, Dr. Hunter noted that one recent suicide at Holman was of an prisoner on the mental health caseload who, although he "was having adjustment issues," was determined to need "no further

intervention…"[212] Dr. Hunter noted, correctly in my view, that "his segregation status placed him at risk for suicide already,"[213] and offered a useful suggestion, namely that "[t]here's a need for closer monitoring or at least a mental health intervention once an inmate is notified officially of a classification in segregation."[214] There is no evidence that anyone has followed through on this otherwise reasonable proposal. In addition, it is a proposal that does not go nearly far enough. Given Chief Psychiatrist Hunter's (and, therefore, presumably, MHM's) awareness of the inherent psychological risks of segregation, and the fact that merely facing the prospect of being placed in segregation can increase an prisoner's potential for self-harm, policies should be adopted to psychologically evaluate or screen all prisoners in Segregation, in advance of their placement and regularly in the course of it, in order to determine whether their mental state precludes such confinement or warrants their removal to a more psychologically appropriate and tolerable setting.

301. A similar failure to implement meaningful policies to address the mental health risks of segregation (of which MHM's representative

[212] Hunter Deposition at p. 219.

[213] Hunter Deposition at p. 219.

[214] Hunter Deposition at p. 221.

appear to be well aware) is the related issue of the mental health staff's potential involvement in the disciplinary process itself. Program Director Houser noted that MHM can act as "an advocate" for an prisoner who is to be placed in Segregation if they feel it is "detrimental to their mental health,"[215] and they can also recommend that an prisoner's segregation time be reduced.[216] However, MHM fails to keep track of whether or how many times they intervene in disciplinary decisions for prisoners on the mental health caseload (if, indeed, they ever do). In addition, because MHM staff is "not responsible for whenever the [disciplinary] hearing is scheduled,"[217] they also do not necessarily even have an opportunity to participate in the hearing so that, presumably, their "input" might not occur until after the fact (when the prisoner has likely already been placed in Segregation).[218]

302. The same systemic failure to act on the basis of the clear recognition and awareness that, as Dr. Hunter put it, "segregation is potentially detrimental to one's health and well-being," occurs with respect to MHM's mental health monitoring in Segregation. For one, MHM's

[215] Houser November Deposition at p. 172.

[216] Houser November Deposition at p. 173.

[217] Houser November Deposition at p. 173.

[218] Houser November Deposition at pp. 174-175.

record-keeping in this regard is problematic. Program Director Houser has acknowledged that she does not know how long mental health staff spend in the Segregation Units,[219] does not think they have set schedules for going into the units, but if there are schedules or records of when they actually do go, she does not know whether they are saved.[220] She also indicated that prisoners who are on the mental health caseload and who are confined to Segregation get structured out-of-cell time that is "the same as any other inmate in seg" (which means very, very little, and sometimes none).[221] This is entirely inappropriate and troubling in the extreme. It underscores the dangerous nature of ADOC's and MHM's policies with respect to the housing of mentally ill prisoners in Segregation, as I have repeatedly emphasized.

303. Beyond the lack of systematic record-keeping and regular scheduling, and the failure to provide mentally ill segregated prisoners with any additional out-of-cell time (beyond the little or no such time that other segregated prisoners receive), the nature of the monitoring that takes place

[219] Clinical Operations Associate Fields also acknowledged that MHM does not record or analyze how much time was spent in counseling or on Segregation monitoring rounds. Fields Deposition at p. 215-6.

[220] Houser November Deposition at p. 177-178.

[221] Houser November Deposition at p. 180.

inside Segregation is itself highly problematic. Dr. Hunter acknowledged that, despite the very serious risks posed by segregated confinement, Segregation rounds in the ADOC consist "somewhat of a drive-by type of process. It's usually done at cell side: How are you doing, how are you getting along; look around inmate's cell, seeing what kind of condition it's in; look at the inmate, see what kind of condition he's in, how he's looking, how he's asking acting [sic], how he's responding to you. And, again, it's pretty cursory, just cell-side visit."[222] Of course, there is always the option of more in-depth follow up, but no more than "cursory" monitoring is actually required. Moreover, as I have noted, out-of-cell contacts and truly confidential contacts—the circumstances under which meaningful assessments can be made—are infrequent if not non-existent.

304. In his discussion of the recent ADOC suicides, Dr. Hunter acknowledged the tragic consequences that can result when suicidal prisoners fail to acknowledge their underlying mental health problems, noting that "most of them gave no indication that they were in any distress, gave no indication that they felt like taking their life. And several of those cases there had been some mental health contact recently, usually in the form of segregation rounds, an inmate didn't display any distress, didn't

[222] Hunter Deposition at p. 192.

articulate any, and was deemed to be okay."[223] In my opinion, the tendency to "give no indication" of distress or suicidality is exacerbated by the substandard mental health care that is being offered in the ADOC (so that prisoners in distress are not under the conscientious care of a clinician and have no reason to believe that their acute problems will be meaningfully addressed) and certainly by the kind of "cursory," "drive-by" mental health monitoring that prisoner after prisoner I interviewed confirmed characterizes these units system-wide.

305. Finally, Program Director Houser acknowledged that MHM talked in early 2015 with ADOC about "how when inmates are detained in a single cell for long periods of time, it will cause—often cause further decompensation in their mental health" and the fact that "these are mental health inmates that need to function in a more therapeutic setting to regain some of their social skills and improve in their abilities to function with the other population."[224] In light of this, it seems essential to introduce transitional programming or a "step down" unit of some sort for mentally ill prisoners who have been in isolation, so that they can, as Ms. Houser says, "regain some of their social skills," if for no other reason than to decrease

[223] Hunter Deposition at pp. 98-99.

[224] Houser November Deposition at p. 66.

the likelihood that they will commit subsequent disciplinary infractions and return to Segregation. Yet, to my knowledge, no such program has been implemented.

306. I have seen no evidence in any of my tours, interviews, or the document reviews I have conducted to suggest that any of the problems that I have discussed in this Report are in the process of being solved. In fact, if anything, there is evidence indicating that ADOC is regressing along a number of dimensions and that the already dangerously inadequate treatment of mentally ill prisoners is worsening. Some of the regression appears to be caused at least in part by the accumulation of the major structural problems that plague the ADOC (which not only, obviously, will not "solve themselves," but also tend to accumulate and get worse over time) and also by increasing shortages in mental health staffing. I noted earlier that, by Dr. Hunter's estimate, there have been substantial increases in the size of the MHM's mental health caseloads—he believes that in some cases they translate into increases of nearly 100% or more, and obviously they are further "taxing" MHM's ability to provide mental health care.

307. Other sources of information confirm Dr. Hunter's conclusions that the mental health staffing situation is getting worse. These trends began several years ago. For example, a February 2013 Clinical Contract

Compliance Report contained this statement: "Despite the increase in the size of the caseload across ADOC, MHM's contract has been compressed to include significant staffing cuts across all sites."[225] Later that year, at a July 2013 CQI meeting, the minutes reported that: "Ms. Fields [sic] concerned that we are still not seeing an increase in inmate therapy groups. There actually has been a decrease in groups at many camps"[226]

308. MHM Program Director Houser provided additional information about worsening mental health staffing over the last several years. Thus, she noted that MHM's FTE proposal for 2013 went from 144.95 original down to 126.5 because MHM was told by ADOC that "the department… wouldn't be able to fund that many employees and we should take that into consideration when we bid."[227] In fact, when the contract was executed, it provided for the lower number of 126.5 full time mental health employees, rather than the number MHM said they needed. Although, as Ms. Fields suggested, MHM "prides itself on the ability to do more with

[225] Quoted in Fields Deposition at p. 274.

[226] Quoted in Fields Deposition, at p. 240 (emphasis added). Ms. Fields also acknowledged, as a number of prisoners told me, that there was a problem with people being taken off the mental health caseload if they refused to take their medications. Fields Deposition at p. 244.

[227] Houser November Deposition at p. 298.

less,"[228] there is a great deal of evidence, much of it cited throughout this Report, and a fair amount of it acknowledged by MHM officials, that quite a bit less is being done. In my opinion, what is being done to provide necessary and adequate mental health care is nowhere near enough, and mentally ill prisoners in the ADOC are suffering as a result.

309. More recently, Brenda Fields, the Clinical Operations Associate for MHM Ms. Fields observed that the shortage of mental health staff—at least at the recently audited Donaldson facility—is "worse" than when she left in 2013, and that the identified failures to complete admission assessments and treatment plans also were worse now than in 2013 when she left. In fact, all of the deficiencies were worse now than they were then (except for the rats that were found in the pharmacy, which apparently were also a problem in 2013).[229]

310. MHM Program Director Teresa Houser acknowledged that MHM asked to add to staffing levels "in order for us to be able to provide services in a more timely way"[230] that the "number of crises that go on on a daily basis… takes away from doing the daily therapeutic things for the

[228] Houser November Deposition at p. 301.

[229] Fields Deposition at p. 129-130.

[230] Houser April Deposition at p. 22.

people on the caseload."[231] She cited Limestone, Bullock Inpatient, Donaldson, Tutwiler, Easterling, and Kilby as facilities that could benefit from having more staff,[232] and then went on to say that none of the named facilities had "enough staff."[233] She also acknowledged that, even if all allocated staff positions were filled at the above named places, they still would be understaffed,[234] and that, taking into account the facilities not on her list of places she said needed more staff, there are vacancies and hence understaffing nearly everywhere, either under the contract or by virtue of vacancies in allocated positions.[235]

311. Not surprisingly, the staffing shortfalls and other unsolved problems with mental health care delivery affect mentally ill prisoners directly. Indeed, there is evidence to suggest that it may have affected them in an increasingly direct and tragic way. For example, since the October 2015 meeting between MHM and ADOC on suicides and segregation, there

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[231] Houser April Deposition at p. 22.

[232] Houser April Deposition at p. 34. She also noted that, in addition to the staffing shortages at all of these other facilities—nearly the entire ADOC system—Bibb needs additional psychiatrist or nurse practitioner time. At p. 38.

[233] Houser April Deposition at pp. 37-38.

[234] Houser April Deposition at p. 40.

[235] Houser April Deposition at p. 40-49.

were two more suicides at Holman.[236] Obviously, the increased overall suicide rate in the ADOC is a cause for concern. Dr. Hunter noted that MHM had been "[v]ery proud of the fact that we've had a very low suicide rate over the years," and he is understandably troubled by "what's happening lately."[237] The prisoners' pre-existing but undetected psychological instability and their fears of being housed in one or another of ADOC's harsh Segregation Units may be playing a role, yet it appears that little or nothing is being done to address it.[238]

312. Moreover, in addition to the worsening staffing shortages per se, there are other staffing-related problems that also appear to be getting worse rather than better. Dr. Hunter acknowledged that the extensive turnover in the ADOC, the number of retirements, and the officers who are moving "up the ladder" to supervisory positions have resulted in this problematic situation: "[M]any of these newer folks do not have benefit [sic] of the experience that we had with mental health in the prior litigation" [apparently referring to short-lived changes brought about years

[236] Hunter Deposition at pp. 212-213.

[237] Hunter Deposition at p. 97.

[238] Dr. Hunter indicated, as I noted, that there was not even a follow-up meeting, let alone the implementation of any changed policies, addressing the Segregation-related concerns that were expressed at the initial joint MHM-ADOC meeting in October, 2015. Hunter Deposition at p. 206.

ago in the Bradley and Laube cases].[239] More specifically, these staff members had not had the benefit of "[t]he training, the commitment to that process of a reform that had gone on during that time."[240]

313. In a related vein, Dr. Hunter also acknowledged that the lack of "officer sensitivity" that had been discussed at meetings years earlier was not getting better and, in fact, as he put it: "I think in some cases it's worse."[241] The reason, he thought, was because of "the shortage that the DOC has in terms of correctional officers," and the fact that, as a result, "the priorities are trying to maintain order in the facility with the few officers they have."[242]

314. As I have discussed throughout this Report, the very real systemic crisis that now plagues the ADOC has resulted in the failure of the Alabama prison system to accomplish either of these goals—it is not able to "maintain order" in its correctional facilities nor to provide necessary and

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[239] Hunter Deposition at p. 203.

[240] Hunter Deposition at p. 204.

[241] Hunter Deposition at p. 205. To cite just one specific case, Teresa Houser acknowledged that the problem of not getting cooperation from custody staff at Donaldson—one of the ADOC "treatment" facilities"—had not been resolved: "it depends on the day and who's working." Houser April Deposition at p. 232.

[242] Hunter Deposition at p. 205.

adequate mental health care to the large population of very vulnerable mentally ill prisoners confined in them.

## VIII. CONCLUSION

315. I have noted repeatedly in the preceding pages that the problems that plague the ADOC are systemic, deep-seated, and long-standing. Without reaching back to the still not-too-distant history of the original statewide Alabama prison cases that occurred in the 1970s, these major problems date at least to the most recent litigation (Bradley) that was undertaken more than a dozen years ago and intended to address many of these very same issues.

316. As I have detailed repeatedly in this Report, those problems persist. They include chronic and dysfunctional levels of overcrowding, a corresponding lack of space and significant levels understaffing, all of which have prevented the effective identification, monitoring and safe treatment of mentally ill prisoners and crippled ADOC's ability to deliver necessary and essential mental health services. In addition, they include the consignment of Alabama prisoners to shockingly bad Segregation Units where prisoners live in deplorable conditions and large numbers of mentally prisoners languish for months or years, all the while at very significant risk of even more grave psychological harm.

317. The levels of suffering that I encountered are not only widespread, but they are also extreme and extremely unsettling. As I mentioned several times in this Report, I have witnessed things in the ADOC—including truly abysmal conditions and shocking levels of neglect and maltreatment of vulnerable and desperately mentally ill prisoners—that I have rarely if ever seen in some 40 years of doing this kind of work, including some things that I am not sure I would have believed if I had not witnessed them firsthand.

318. As I have indicated throughout, these are deep-seated, inter-related systemic problems that reach across the entire ADOC, including the conditions of confinement to which prisoners are subjected, and the policies and practices that affect them on a day-to-day basis. The problems not only will not solve themselves but, perhaps because they are so long-standing and systemic, there is evidence to suggest that they are worsening. In any event, they will continue to have wide-ranging, damaging effects on Alabama's inmates, especially those inmates who suffer from mental illness, unless decisive and systemic action is taken to reverse course. Such truly broad-based action, in fact, has the potential to succeed and is urgently needed.

Submitted and signed:

July 5, 2016 in Santa Cruz, California

Craig Haney Ph.D., J.D.

Craig Haney, Ph.D., J.D.

# Exhibit 1

CURRICULUM VITAE

Craig William Haney
Distinguished Professor of Psychology
UC Presidential Chair, 2015-2018

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## PREVIOUS EMPLOYMENT

| | |
|---|---|
| 2015-2018 | University of California Presidential Chair |
| 2014-present | Distinguished Professor of Psychology, University of California, Santa Cruz |
| 1985-2014 | University of California, Santa Cruz, Professor of Psychology |
| 1981-85 | University of California, Santa Cruz, Associate Professor of Psychology |
| 1978-81 | University of California, Santa Cruz, Assistant Professor of Psychology |
| 1977-78 | University of California, Santa Cruz, Lecturer in Psychology |
| 1976-77 | Stanford University, Acting Assistant Professor of Psychology |

## EDUCATION

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| 1978 | Stanford Law School, J.D. |

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| 1978 | Stanford University, Ph.D. (Psychology) |
| 1972 | Stanford University, M.A. (Psychology) |
| 1970 | University of Pennsylvania, B.A. |

HONORS AWARDS GRANTS

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| 2016 | Vera Institute of Justice "Reimagining Prisons" Initiative Advisory Council. |
| | Psychology Department "Most Inspiring Lecturer" |
| 2015 | University of California Presidential Chair (2015-2018 Term) |
| | Martin F. Chemers Award for Outstanding Research in Social Science |
| | Excellence in Teaching Award (Academic Senate Committee on Teaching). |
| | President's Research Catalyst Award for "UC Consortium on Criminal Justice Healthcare" (with Brie Williams and Scott Allen). |
| | Vera Institute of Justice "Safe Alternatives to Segregation" (SAS) Initiative Advisory Council. |
| | Who's Who in Psychology (Top 20 Psychology Professors in California) [http://careersinpsychology.org/psychology-degrees-schools-employment-ca/#ca-psych-prof] |
| 2014 | Distinguished Faculty Research Lecturer, University of California, Santa Cruz. |
| 2013 | Distinguished Plenary Speaker, American Psychological Association Annual Convention. |
| 2012 | Appointed to National Academy of Sciences Committee to Study the Causes and Consequences of High Rates of Incarceration in the United States. |
| | Invited Expert Witness, United States Senate, Judiciary Committee. |
| 2011 | Edward G. Donnelly Memorial Speaker, University of West Virginia Law School. |

2009 Nominated as American Psychological Foundation William Bevan Distinguished Lecturer.

Psi Chi "Best Lecturer" Award (by vote of UCSC undergraduate psychology majors).

2006 Herbert Jacobs Prize for Most Outstanding Book published on law and society in 2005 (from the Law & Society Association, for Death by Design).

Nominated for National Book Award (by American Psychological Association Books, for Reforming Punishment: Psychological Limits to the Pains of Imprisonment).

"Dream course" instructor in psychology and law, University of Oklahoma.

2005 Annual Distinguished Faculty Lecturer, University of California, Santa Cruz.

Arthur C. Helton Human Rights Award from the American Immigration Lawyers Association (co-recipient).

Scholar-in-Residence, Center for Social Justice, Boalt Hall School of Law (University of California, Berkeley).

2004 "Golden Apple Award" for Distinguished Teaching, awarded by the Social Sciences Division, University of California, Santa Cruz.

National Science Foundation Grant to Study Capital Jury Decision-making

2002 Santa Cruz Alumni Association Distinguished Teaching Award, University of California, Santa Cruz.

United States Department of Health & Human Services/Urban Institute, "Effects of Incarceration on Children, Families, and Low-Income Communities" Project.

American Association for the Advancement of Science/American Academy of Forensic Science Project: "Scientific Evidence Summit" Planning Committee.

Teacher of the Year (UC Santa Cruz Re-Entry Students' Award).

2000 Invited Participant White House Forum on the Uses of Science and

Technology to Improve National Crime and Prison Policy.

Excellence in Teaching Award (Academic Senate Committee on Teaching).

Joint American Association for the Advancement of Science-American Bar Association Science and Technology Section National Conference of Lawyers and Scientists.

1999 American Psychology-Law Society Presidential Initiative Invitee ("Reviewing the Discipline: A Bridge to the Future")

National Science Foundation Grant to Study Capital Jury Decision-making (renewal and extension).

1997 National Science Foundation Grant to Study Capital Jury Decision-making.

1996 Teacher of the Year (UC Santa Cruz Re-Entry Students' Award).

1995 Gordon Allport Intergroup Relations Prize (Honorable Mention)

Excellence in Teaching Convocation, Social Sciences Division

1994 Outstanding Contributions to Preservation of Constitutional Rights, California Attorneys for Criminal Justice.

1992 Psychology Undergraduate Student Association Teaching Award

SR 43 Grant for Policy-Oriented Research With Linguistically Diverse Minorities

1991 Alumni Association Teaching Award ("Favorite Professor")

1990 Prison Law Office Award for Contributions to Prison Litigation

1989 UC Mexus Award for Comparative Research on Mexican Prisons

1976 Hilmer Oehlmann Jr. Award for Excellence in Legal Writing at Stanford Law School

1975-76 Law and Psychology Fellow, Stanford Law School

1974-76 Russell Sage Foundation Residency in Law and Social Science

1974 Gordon Allport Intergroup Relations Prize, Honorable Mention

| | |
|---|---|
| 1969-71 | University Fellow, Stanford University |
| 1969-74 | Society of Sigma Xi |
| 1969 | B.A. Degree Magna cum laude with Honors in Psychology |
| | Phi Beta Kappa |
| 1967-1969 | University Scholar, University of Pennsylvania |

## UNIVERSITY SERVICE AND ADMINISTRATION

| | |
|---|---|
| 2010-present | Director, Legal Studies Program |
| 2010-2014 | Director, Graduate Program in Social Psychology |
| 2009 | Chair, Legal Studies Review Committee |
| 2004-2006 | Chair, Committee on Academic Personnel |
| 1998-2002 | Chair, Department of Psychology |
| 1994-1998 | Chair, Department of Sociology |
| 1992-1995 | Chair, Legal Studies Program |
| 1995 (Fall) | Committee on Academic Personnel |
| 1995-1996 | University Committee on Academic Personnel (UCAP) |
| 1990-1992 | Committee on Academic Personnel |
| 1991-1992 | Chair, Social Science Division Academic Personnel Committee |
| 1984-1986 | Chair, Committee on Privilege and Tenure |

## WRITINGS AND OTHER CREATIVE ACTIVITIES IN PROGRESS

Books:

Context and Criminality: Deconstructing the Crime Master Narrative (working title, in preparation).

Articles:

"The Psychological Foundations of Capital Mitigation: Why Social Historical Factors Are Central to Assessing Culpability," in preparation.

## PUBLISHED WRITINGS AND CREATIVE ACTIVITIES

### Books

2014 The Growth of Incarceration in the United States: Exploring the Causes and Consequences (with Jeremy Travis, Bruce Western, et al.). [Report of the National Academy of Sciences Committee on the Causes and Consequences of High Rates of Incarceration in the United States.] Washington, DC: National Academy Press.

2006 Reforming Punishment: Psychological Limits to the Pains of Imprisonment, Washington, DC: American Psychological Association Books.

2005 Death by Design: Capital Punishment as a Social Psychological System. New York: Oxford University Press.

### Monographs and Technical Reports

1989 Employment Testing and Employment Discrimination (with A. Hurtado). Technical Report for the National Commission on Testing and Public Policy. New York: Ford Foundation.

### Articles in Professional Journals and Book Chapters

2016 "Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful" (with Joanna Weill, Shirin Bakhshay, and Tiffany Winslow), The Prison Journal, 96, 126-152.

"On Structural Evil: Disengaging From Our Moral Selves," Review of the book Moral Disengagement: How People Do Harm and Live With Themselves, by A. Bandura], PsycCRITIQUES, 61(8).

2015 "When Did Prisons Become Acceptable Mental Healthcare Facilities?," Report of the Stanford Law School Three Strikes Project (with Michael Romano et al.) [available at: http://law.stanford.edu/wp-content/uploads/sites/default/files/child-page/632655/doc/slspublic/Report_v12.pdf ].

"Emotion, Authority, and Death: (Raced) Negotiations in Capital Jury Negotiations" (with Mona Lynch), Law & Social Inquiry, 40, 377-405.

"Prison Overcrowding," in B. Cutler & P. Zapf (Eds.), APA Handbook of Forensic Psychology (pp. 415-436). Washington, DC: APA Books.

"The Death Penalty" (with Joanna Weill & Mona Lynch), in B. Cutler & P. Zapf (Eds.), APA Handbook of Forensic Psychology (pp. 451-510). Washington, DC: APA Books.

"'Prisonization' and Latinas in Alternative High Schools" (with Aida Hurtado & Ruby Hernandez), in J. Hall (Ed.), Routledge Studies in Education and Neoliberalism: Female Students and Cultures of Violence in the City (pp. 113-134). Florence, KY: Routledge.

2014 "How Healthcare Reform Can Transform the Health of Criminal Justice-Involved Individuals" (with Josiah Rich, et al.), Health Affairs, 33:3 (March), 1-6.

2013 "Foreword," for H. Toch, Organizational Change Through Individual Empowerment: Applying Social Psychology in Prisons and Policing. Washington, DC: APA Books (in press).

"Foreword," for J. Ashford & M. Kupferberg, Death Penalty Mitigation: A Handbook for Mitigation Specialists, Investigators, Social Scientists, and Lawyers. New York: Oxford University Press.

2012 "Politicizing Crime and Punishment: Redefining 'Justice' to Fight the 'War on Prisoners,'" West Virginia Law Review, 114, 373-414.

"Prison Effects in the Age of Mass Imprisonment," Prison Journal, 92, 1-24.

"The Psychological Effects of Imprisonment," in J. Petersilia & K. Reitz (Eds.), Oxford Handbook of Sentencing and Corrections (pp. 584-605). New York: Oxford University Press.

2011 "The Perversions of Prison: On the Origins of Hypermasculinity and Sexual Violence in Confinement," American Criminal Law Review, 48, 121-141. [Reprinted in: S. Ferguson (Ed.), Readings in Race, Gender, Sexuality, and Social Class. Sage Publications (2012).]

"Mapping the Racial Bias of the White Male Capital Juror: Jury Composition and the 'Empathic Divide'" (with Mona Lynch), Law and Society Review, 45, 69-102.

"Getting to the Point: Attempting to Improve Juror Comprehension of Capital Penalty Phase Instructions" (with Amy Smith), Law and Human Behavior, 35, 339-350.

"Where the Boys Are: Macro and Micro Considerations for the Study of Young Latino Men's Educational Achievement" (with A. Hurtado & J. Hurtado), in P. Noguera & A. Hurtado (Eds.), Understanding the Disenfranchisement of Latino Males: Contemporary Perspectives on Cultural and Structural Factors (pp. 101-121). New York: Routledge Press.

"Looking Across the Empathic Divide: Racialized Decision-Making on the Capital Jury" (with Mona Lynch), Michigan State Law Review, 2011, 573-608.

2010 "Demonizing the 'Enemy': The Role of Science in Declaring the 'War on Prisoners,'" Connecticut Public Interest Law Review, 9, 139-196.

"Hiding From the Death Penalty," Huffington Post, July 26, 2010 [www.huffingtonpost.com/craig-haney/hiding-from-the-death-pen-pen_b_659940.html]; reprinted in Sentencing and Justice Reform Advocate, 2, 3 (February, 2011).

2009 "Capital Jury Deliberation: Effects on Death Sentencing, Comprehension, and Discrimination" (with Mona Lynch), Law and Human Behavior, 33, 481-496.

"The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful," Prison Service Journal UK (Solitary

Confinement Special Issue), Issue 181, 12-20. [Reprinted: California Prison Focus, #36, 1, 14-15 (2011).]

"The Stanford Prison Experiment," in John Levine & Michael Hogg (Eds.), Encyclopedia of Group Processes and Intergroup Relations. Thousand Oaks, CA: Sage Publications.

"Media Criminology and the Death Penalty," DePaul Law Review, 58, 689-740. (Reprinted: Capital Litigation Update, 2010.)

"On Mitigation as Counter-Narrative: A Case Study of the Hidden Context of Prison Violence," University of Missouri-Kansas City Law Review, 77, 911-946.

"Persistent Dispositionalism in Interactionist Clothing: Fundamental Attribution Error in Explaining Prison Abuse," (with P. Zimbardo), Personality and Social Psychology Bulletin, 35, 807-814.

2008 "Counting Casualties in the War on Prisoners," University of San Francisco Law Review, 43, 87-138.

"Evolving Standards of Decency: Advancing the Nature and Logic of Capital Mitigation," Hofstra Law Review, 36, 835-882.

"A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons," Criminal Justice and Behavior, 35, 956-984.

"The Consequences of Prison Life: Notes on the New Psychology of Prison Effects," in D. Canter & R. Zukauskiene (Eds.), Psychology and Law: Bridging the Gap (pp. 143-165). Burlington, VT: Ashgate Publishing.

"The Stanford Prison Experiment," in J. Bennett & Y. Jewkes (Eds.), Dictionary of Prisons (pp. 278-280). Devon, UK: Willan Publishers.

"Capital Mitigation," in Brian Cutler (Ed.), The Encyclopedia of Psychology and the Law (pp. 60-63). Volume I. Thousand Oaks, CA: Sage Publications.

Death Qualification of Juries," in Brian Cutler (Ed.), The Encyclopedia of Psychology and the Law (pp. 190-192). Volume I. Thousand Oaks, CA: Sage Publications.

"Stanford Prison Experiment," in Brian Cutler (Ed.), The Encyclopedia of Psychology and the Law (pp. 756-757) (with P. Zimbardo). Volume II. Thousand Oaks, CA: Sage Publications.

"Supermax Prisons," in Brian Cutler (Ed.), The Encyclopedia of Psychology and the Law (pp. 787-790). Volume II. Thousand Oaks, CA: Sage Publications.

2006 "The Wages of Prison Overcrowding: Harmful Psychological Consequences and Dysfunctional Correctional Reactions," Washington University Journal of Law & Policy, 22, 265-293. [Reprinted in: N. Berlatsky, Opposing Viewpoints: America's Prisons. Florence, KY: Cengage Learning, 2010.]

"Exonerations and Wrongful Condemnations: Expanding the Zone of Perceived Injustice in Capital Cases," Golden Gate Law Review, 37, 131-173.

"Preface," D. Jones (Ed.), Humane Prisons. San Francisco, CA: Radcliffe Medical Press.

2005 "The Contextual Revolution in Psychology and the Question of Prison Effects," in Alison Liebling and Shadd Maruna (Eds.), The Effects of Imprisonment (pp. 66-93). Devon, UK: Willan Publishing.

"Achieving Educational Equity: Beyond Individual Measures of Merit," (with A. Hurtado), Harvard Journal of Hispanic Policy, 17, 87-92.

"Conditions of Confinement for Detained Asylum Seekers Subject to Expedited Removal," in M. Hetfield (Ed.), Report on Asylum Seekers in Expedited Removal. Volume II: Expert Reports. Washington, DC: United States Commission on International Religious Freedom.

2004 "Special Issue on the Death Penalty in the United States" (co-edited with R. Weiner), Psychology, Public Policy, and Law, 10, 374-621.

"Death Is Different: An Editorial Introduction" (with R. Wiener), Psychology, Public Policy, and Law, 10, 374-378.

"The Death Penalty in the United States: A Crisis of Conscience" (with R. Wiener), Psychology, Public Policy, and Law, 10, 618-621.

"Condemning the Other in Death Penalty Trials: Biographical Racism, Structural Mitigation, and the Empathic Divide," DePaul Law Review, 53, 1557-1590.

"Capital Constructions: Newspaper Reporting in Death Penalty Cases" (with S. Greene), Analyses of Social Issues and Public Policy (ASAP), 4, 1-22.

"Abu Ghraib and the American Prison System," The Commonwealth, 98 (#16), 40-42.

"Disciplinary Segregation," in Mary Bosworth (Ed.), Encyclopedia of U.S. Prisons and Correctional Facilities (240-244). Volume 1. Thousand Oaks, CA: Sage Publications.

"Super-Maximum Secure Prisons," in Mary Bosworth (Ed.), Encyclopedia of U.S. Prisons and Correctional Facilities (pp. 938-944). Volume 2. Thousand Oaks, CA: Sage Publications.

2003 "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," Crime & Delinquency (special issue on mental health and the criminal justice system), 49, 124-156. [Reprinted in: Roesch, R., & Gagnon, N. (Eds.), Psychology and Law: Criminal and Civil Perspectives. Hampshire, UK: Ashgate (2007).]

"The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment," in Travis, J., & Waul, M. (Eds.), Prisoners Once Removed: The Impact of Incarceration and Reentry on Children, Families, and Communities (pp. 33-66). Washington, DC: Urban Institute Press.

"Comments on "Dying Twice": Death Row Confinement in the Age of the Supermax," Capital University Law Review.

2002 "Making Law Modern: Toward a Contextual Model of Justice, Psychology, Public Policy, and Law, 7, 3-63.

"Psychological Jurisprudence: Taking Psychology and Law into the Twenty-First Century," (with John Darley, Sol Fulero, and Tom Tyler), in J. Ogloff (Ed.), Taking Psychology and Law into the Twenty-First Century (pp. 35-59). New York: Kluwer Academic/ Plenum Publishing.

"Science, Law, and Psychological Injury: The Daubert Standards and Beyond," (with Amy Smith), in Schultz, I., Brady, D., and Carella, S., The Handbook of Psychological Injury (pp. 184-201). Chicago, IL: American Bar Association. [CD-ROM format]

2001 "Vulnerable Offenders and the Law: Treatment Rights in Uncertain Legal Times" (with D. Specter). In J. Ashford, B. Sales, & W. Reid (Eds.), Treating Adult and Juvenile Offenders with Special Needs (pp. 51-79). Washington, D.C.: American Psychological Association.

"Afterword," in J. Evans (Ed.), Undoing Time (pp. 245-256). Boston, MA: Northeastern University Press.

2000 "Discrimination and Instructional Comprehension: Guided Discretion, Racial Bias, and the Death Penalty" (with M. Lynch), Law and Human Behavior, 24, 337-358.

"Cycles of Pain: Risk Factors in the Lives of Incarcerated Women and Their Children," (with S. Greene and A. Hurtado), Prison Journal, 80, 3-23.

1999 "Reflections on the Stanford Prison Experiment: Genesis, Transformations, Consequences ('The SPE and the Analysis of Institutions')," In Thomas Blass (Ed.), Obedience to Authority: Current Perspectives on the Milgram Paradigm (pp. 221-237). Hillsdale, NJ: Erlbaum.

"Ideology and Crime Control," American Psychologist, 54, 786-788.

1998 "The Past and Future of U.S. Prison Policy: Twenty-Five Years After the Stanford Prison Experiment," (with P. Zimbardo), American Psychologist, 53, 709-727. [Reprinted in special issue of Norweigian journal as: USAs fengselspolitikk i fortid og fremtid, Vardoger, 25, 171-183 (2000); in H. Tischler (Ed.), Debating Points: Crime and Punishment. Englewood Cliffs, NJ: Prentice-Hall (2001); Annual Editions: Criminal Justice. Guilford, CT: Dushkin/McGraw-Hill, in press; Herman, Peter (Ed.), The American Prison System (pp. 17-43) (Reference Shelf Series). New York: H.W. Wilson (2001); and in Edward Latessa & Alexander Holsinger (Eds.), Correctional Contexts: Contemporary and Classical Readings. Fourth Edition. Oxford University Press (2010).]

"Riding the Punishment Wave: On the Origins of Our Devolving Standards of Decency," Hastings Women's Law Journal, 9, 27-78.

"Becoming the Mainstream: "Merit," Changing Demographics, and Higher Education in California" (with A. Hurtado and E. Garcia), La Raza Law Journal, 10, 645-690.

1997 "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," (with M. Lynch), New York University Review of Law and Social Change, 23, 477-570.

"Psychology and the Limits to Prison Pain: Confronting the Coming Crisis in Eighth Amendment Law," Psychology, Public Policy, and Law, 3, 499-588.

"Commonsense Justice and the Death Penalty: Problematizing the 'Will of the People,'" Psychology, Public Policy, and Law, 3, 303-337.

"Violence and the Capital Jury: Mechanisms of Moral Disengagement and the Impulse to Condemn to Death," Stanford Law Review, 49, 1447-1486.

"Mitigation and the Study of Lives: The Roots of Violent Criminality and the Nature of Capital Justice." In James Acker, Robert Bohm, and Charles Lanier, America's Experiment with Capital Punishment: Reflections on the Past, Present, and Future of the Ultimate Penal Sanction. Durham, NC: Carolina Academic Press, 343-377.

"Clarifying Life and Death Matters: An Analysis of Instructional Comprehension and Penalty Phase Arguments" (with M. Lynch), Law and Human Behavior, 21, 575-595.

"Psychological Secrecy and the Death Penalty: Observations on 'the Mere Extinguishment of Life,'" Studies in Law, Politics, and Society, 16, 3-69.

1995 "The Social Context of Capital Murder: Social Histories and the Logic of Capital Mitigation," Santa Clara Law Review, 35, 547-609. [Reprinted in part in David Papke (Ed.), Law and Popular Culture, Lexis/Nexis Publications, 2011)].

"Taking Capital Jurors Seriously," Indiana Law Journal, 70, 1223-1232.

"Death Penalty Opinion: Myth and Misconception," California Criminal Defense Practice Reporter, 1995(1), 1-7.

1994 "The Jurisprudence of Race and Meritocracy: Standardized Testing and 'Race-Neutral' Racism in the Workplace," (with A. Hurtado), Law and Human Behavior, 18, 223-248.

"Comprehending Life and Death Matters: A Preliminary Study of California's Capital Penalty Instructions" (with M. Lynch), Law and Human Behavior, 18, 411-434.

"Felony Voir Dire: An Exploratory Study of Its Content and Effect," (with C. Johnson), Law and Human Behavior, 18, 487-506.

"Broken Promise: The Supreme Court's Response to Social Science Research on Capital Punishment" (with D. Logan), Journal of Social Issues (special issue on the death penalty in the United States), 50, 75-101.

"Deciding to Take a Life: Capital Juries, Sentencing Instructions, and the Jurisprudence of Death" (with L. Sontag and S. Costanzo), Journal of Social Issues (special issue on the death penalty in the United States), 50, 149-176. [Reprinted in Koosed, M. (Ed.), Capital Punishment. New York: Garland Publishing (1995).]

"Modern' Death Qualification: New Data on Its Biasing Effects," (with A. Hurtado and L. Vega), Law and Human Behavior, 18, 619-633.

"Processing the Mad, Badly," Contemporary Psychology, 39, 898-899.

"Language is Power," Contemporary Psychology, 39, 1039-1040.

1993 "Infamous Punishment: The Psychological Effects of Isolation," National Prison Project Journal, 8, 3-21. [Reprinted in Marquart, James & Sorensen, Jonathan (Eds.), Correctional Contexts: Contemporary and Classical Readings (pp. 428-437). Los Angeles: Roxbury Publishing (1997); Alarid, Leanne & Cromwell, Paul (Eds.), Correctional Perspectives: Views from Academics, Practitioners, and Prisoners (pp. 161-170). Los Angeles: Roxbury Publishing (2001).]

"Psychology and Legal Change: The Impact of a Decade," Law and Human Behavior, 17, 371-398. [Reprinted in: Roesch, R., & Gagnon, N. (Eds.), Psychology and Law: Criminal and Civil Perspectives. Hampshire, UK: Ashgate (2007).]

1992 "Death Penalty Attitudes: The Beliefs of Death-Qualified Californians," (with A. Hurtado and L. Vega). Forum, 19, 43-47.

"The Influence of Race on Sentencing: A Meta-Analytic Review of Experimental Studies." (with L. Sweeney). Special issue on Discrimination and the Law. Behavioral Science and Law, 10, 179-195.

1991 "The Fourteenth Amendment and Symbolic Legality: Let Them Eat Due Process," Law and Human Behavior, 15, 183-204.

1988 "In Defense of the Jury," Contemporary Psychology, 33, 653-655.

1986 "Civil Rights and Institutional Law: The Role of Social Psychology in Judicial Implementation," (with T. Pettigrew), Journal of Community Psychology, 14, 267-277.

1984 "Editor's Introduction. Special Issue on Death Qualification," Law and Human Behavior, 8, 1-6.

"On the Selection of Capital Juries: The Biasing Effects of Death Qualification," Law and Human Behavior, 8, 121-132.

"Examining Death Qualification: Further Analysis of the Process Effect," Law and Human Behavior, 8, 133-151.

"Evolving Standards and the Capital Jury," Law and Human Behavior, 8, 153-158.

"Postscript," Law and Human Behavior, 8, 159.

"Social Factfinding and Legal Decisions: Judicial Reform and the Use of Social Science." In Muller, D., Blackman, D., and Chapman, A. (Eds.), Perspectives in Psychology and Law. New York: John Wiley, pp. 43-54.

1983 "The Future of Crime and Personality Research: A Social Psychologist's View," in Laufer, W. and Day, J. (Eds.), Personality Theory, Moral Development, and Criminal Behavioral Behavior. Lexington, Mass.: Lexington Books, pp. 471-473.

"The Good, the Bad, and the Lawful: An Essay on Psychological Injustice," in Laufer, W. and Day, J. (Eds.), Personality Theory, Moral Development, and Criminal Behavior. Lexington, Mass.: Lexington Books, pp. 107-117.

"Ordering the Courtroom, Psychologically," Jurimetrics, 23, 321-324.

1982 "Psychological Theory and Criminal Justice Policy: Law and Psychology in the 'Formative Era,'" Law and Human Behavior, 6, 191-235. [Reprinted in Presser, S. and Zainaldin, J. (Eds.), Law and American History: Cases and Materials. Minneapolis, MN: West Publishing, 1989; and in C. Kubrin, T. Stucky & A. Tynes (Eds.) Introduction to Criminal Justice: A Sociological Perspective. Palo Alto, CA: Stanford University Press (2012).]

"Data and Decisions: Social Science and Judicial Reform," in P. DuBois (Ed.), The Analysis of Judicial Reform. Lexington, Mass.: D.C. Heath, pp. 43-59.

"Employment Tests and Employment Discrimination: A Dissenting Psychological Opinion," Industrial Relations Law Journal, 5, pp. 1-86.

"To Polygraph or Not: The Effects of Preemployment Polygraphing on Work-Related Attitudes," (with L. White and M. Lopez), Polygraph, 11, 185-199.

1981 "Death Qualification as a Biasing Legal Process," The Death Penalty Reporter, 1 (10), pp. 1-5. [Reprinted in Augustus: A Journal of Progressive Human Sciences, 9(3), 9-13 (1986).]

1980 "Juries and the Death Penalty: Readdressing the Witherspoon Question," Crime and Delinquency, October, pp. 512-527.

"Psychology and Legal Change: On the Limits of a Factual Jurisprudence," Law and Human Behavior, 6, 191-235. [Reprinted in Loh, Wallace (Ed.), Social Research and the Judicial Process. New York: Russell Sage, 1983.]

"The Creation of Legal Dependency: Law School in a Nutshell" (with M. Lowy), in R. Warner (Ed.), The People's Law Review. Reading, Mass.: Addison-Wesley, pp. 36-41.

"Television Criminology: Network Illusions of Criminal Justice Realities" (with J. Manzolati), in E. Aronson (Ed.), Readings on the Social Animal. San Francisco, W.H. Freeman, pp. 125-136.

1979 "A Psychologist Looks at the Criminal Justice System," in A. Calvin (Ed.), Challenges and Alternatives to the Criminal Justice System. Ann Arbor: Monograph Press, pp. 77-85.

"Social Psychology and the Criminal Law," in P. Middlebrook (Ed.), Social Psychology and Modern Life. New York: Random House, pp. 671-711.

"Bargain Justice in an Unjust World: Good Deals in the Criminal Courts" (with M. Lowy), Law and Society Review, 13, pp. 633-650. [Reprinted in Kadish, Sanford and Paulsen, Robert (Eds.), Criminal Law and Its Processes. Boston: Little, Brown, 1983.]

1977 "Prison Behavior" (with P. Zimbardo), in B. Wolman (Ed.), The Encyclopedia of Neurology, Psychiatry, Psychoanalysis, and Psychology, Vol. IX, pp. 70-74.

"The Socialization into Criminality: On Becoming a Prisoner and a Guard" (with P. Zimbardo), in J. Tapp and F. Levine (Eds.), Law, Justice, and the Individual in Society: Psychological and Legal Issues (pp. 198-223). New York: Holt, Rinehart, and Winston.

1976 "The Play's the Thing: Methodological Notes on Social Simulations," in P. Golden (Ed.), The Research Experience, pp. 177-190. Itasca, IL: Peacock.

1975 "The Blackboard Penitentiary: It's Tough to Tell a High School from a Prison" (with P. Zimbardo). Psychology Today, 26ff.

"Implementing Research Results in Criminal Justice Settings," Proceedings, Third Annual Conference on Corrections in the U.S. Military, Center for Advanced Study in the Behavioral Sciences, June 6-7.

"The Psychology of Imprisonment: Privation, Power, and Pathology" (with P. Zimbardo, C. Banks, and D. Jaffe), in D. Rosenhan and P. London (Eds.), Theory and Research in Abnormal Psychology. New York: Holt Rinehart, and Winston. [Reprinted in: Rubin, Z. (Ed.), Doing Unto Others: Joining, Molding, Conforming, Helping, Loving. Englewood Cliffs: Prentice-Hall, 1974. Brigham, John, and Wrightsman, Lawrence (Eds.) Contemporary Issues in Social Psychology. Third Edition. Monterey: Brooks/Cole, 1977. Calhoun, James Readings, Cases, and Study Guide for Psychology of Adjustment and Human Relationships. New York: Random House, 1978; translated as: La Psicologia del encarcelamiento: privacion, poder y patologia, Revisita de Psicologia Social, 1, 95-105 (1986).]

1973 "Social Roles, Role-Playing, and Education" (with P. Zimbardo), The Behavioral and Social Science Teacher, Fall, 1(1), pp. 24-45. [Reprinted in: Zimbardo, P., and Maslach, C. (Eds.) Psychology For Our Times. Glenview, Ill.: Scott, Foresman, 1977. Hollander, E. and Hunt, R. (Eds.) Current Perspectives in Social Psychology. Third Edition. New York: Oxford University Press, 1978.]

"The Mind is a Formidable Jailer: A Pirandellian Prison" (with P. Zimbardo, C. Banks, and D. Jaffe), The New York Times Magazine, April 8, Section 6, 38-60. [Reprinted in Krupat, E. (Ed.), Psychology Is Social: Readings and Conversations in Social Psychology. Glenview, Ill.: Scott, Foresman, 1982.]

"Interpersonal Dynamics in a Simulated Prison" (with C. Banks and P. Zimbardo), International Journal of Criminology and Penology, 1, pp. 69-97. [Reprinted in: Steffensmeier, Darrell, and Terry, Robert (Eds.) Examining Deviance Experimentally. New York: Alfred Publishing, 1975; Golden, P. (Ed.) The Research Experience. Itasca, Ill.: Peacock, 1976; Leger, Robert (Ed.) The Sociology of Corrections. New York: John Wiley, 1977; A kiserleti tarsadalom-lelektan foarma. Budapest, Hungary: Gondolat Konyvkiado, 1977; Johnston, Norman, and Savitz, L. Justice and Corrections. New York: John Wiley, 1978; Research Methods in Education and Social Sciences. The Open University, 1979; Goldstein, J. (Ed.), Modern Sociology. British Columbia: Open Learning Institute, 1980; Ross, Robert R. (Ed.), Prison Guard/ Correctional Officer: The Use and Abuse of Human Resources of Prison. Toronto: Butterworth's 1981; Monahan, John, and Walker, Laurens (Eds.), Social Science in Law: Cases, Materials, and Problems. Foundation Press, 1985: Siuta, Jerzy (Ed.), The Context of Human Behavior. Jagiellonian University Press, 2001; Ferguson, Susan (Ed.), Mapping the Social Landscape: Readings in Sociology. St. Enumclaw, WA: Mayfield

Publishing, 2001 & 2010; Pethes, Nicolas (Ed.), Menschenversuche (Experiments with Humans). Frankfurt, Germany: Suhrkamp Verlag, 2006.]

"A Study of Prisoners and Guards" (with C. Banks and P. Zimbardo). Naval Research Reviews, 1-17. [Reprinted in Aronson, E. (Ed.) Readings About the Social Animal. San Francisco: W.H. Freeman, 1980; Gross, R. (Ed.) Key Studies in Psychology. Third Edition. London: Hodder & Stoughton, 1999; Collier, C. (Ed.), Basic Themes in Law and Jurisprudence. Anderson Publishing, 2000.]

## MEMBERSHIP/ACTIVITIES IN PROFESSIONAL ASSOCIATIONS

American Psychological Association

American Psychology and Law Society

Law and Society Association

National Council on Crime and Delinquency

## INVITED ADDRESSES AND PAPERS PRESENTED AT PROFESSIONAL ACADEMIC MEETINGS AND RELATED SETTINGS (SELECTED)

2016 "The Culture of Punishment," American Justice Summit, New York, January.

"Mental Illness and Prison Confinement," Conference on Race, Class, Gender and Ethnicity (CRCGE), University of North Carolina Law School, Chapel Hill, NC, February.

"Isolation and Mental Health," International and Inter-Disciplinary Perspectives on Prolonged Solitary Confinement, University of Pittsburgh Law School, Pittsburgh, PA, April.

2015 "Reforming the Criminal Justice System," Bipartisan Summit on Criminal Justice Reform, American Civil Liberties Union/Koch Industries co-sponsored, Washington, DC, March.

"The Intellectual Legacy of the Civil Rights Movement: Two Fifty-Year Anniversaries," College 10 Commencement Address, June.

"Race and Capital Mitigation," Perspectives on Racial and Ethnic Bias for Capital and Non-Capital Lawyers, New York, September.

"Mental Health and Administrative Segregation," Topical Working Group on the Use of Administrative Segregation in the U.S., National Institute of Justice, Washington, DC, October.

"The Psychological Effects of Segregated Confinement," Ninth Circuit Court of Appeals "Corrections Summit," Sacramento, CA, November.

2014 "Solitary Confinement: Legal, Clinical, and Neurobiological Perspectives," American Association for the Advancement of Science (AAAS), Chicago, IL February.

"Overcrowding, Isolation, and Mental Health Care, Prisoners' Access to Justice: Exploring Legal, Medical, and Educational Rights," University of California, School of Law, Irvine, CA, February.

"Community of Assessment of Public Safety," Community Assessment Project of Santa Cruz County, Year 20, Cabrillo College, November.

"Overview of National Academy of Sciences Report on Causes and Consequences of High Rates of Incarceration," Chief Justice Earl Warren Institute on Law & Social Policy, Boalt Hall Law School, Berkeley, CA, November.

"Presidential Panel, Overview of National Academy of Sciences Report on Causes and Consequences of High Rates of Incarceration," American Society for Criminology, San Francisco, November.

"Presidential Panel, National Academy of Sciences Report on Consequences of High Rates of Incarceration on Individuals," American Society for Criminology, San Francisco, November.

"Findings of National Academy of Sciences Committee on the Causes and Consequences of High Rates of Incarceration," Association of Public Policy Analysis and Management Convention (APPAM), Albuquerque, NM, November.

2013 "Isolation and Mental Health," Michigan Journal of Race and Law Symposium, University of Michigan School of Law, Ann Arbor, MI, February.

"Bending Toward Justice: Psychological Science and Criminal Justice Reform," Invited Plenary Address, American Psychological Association Annual Convention, Honolulu, HI, August.

"Severe Conditions of Confinement and International Torture Standards," Istanbul Center for Behavior Research and Therapy, Istanbul, Turkey, December.

2012 "The Psychological Consequences of Long-term Solitary Confinement," Joint Yale/Columbia Law School Conference on Incarceration and Isolation, New York, April.

"The Creation of the Penal State in America," Managing Social Vulnerability: The Welfare and Penal System in Comparative Perspective, Central European University, Budapest, Hungary, July.

2011 "Tensions Between Psychology and the Criminal Justice System: On the Persistence of Injustice," opening presentation, "A Critical Eye on Criminal Justice" lecture series, Golden Gate University Law School, San Francisco, CA, January.

"The Decline in Death Penalty Verdicts and Executions: The Death of Capital Punishment?" Presentation at "A Legacy of Justice" week, at the University of California, Davis King Hall Law School, Davis, CA, January.

"Invited Keynote Address: The Nature and Consequences of Prison Overcrowding—Urgency and Implications," West Virginia School of Law, Morgantown, West Virginia, March.

"Symposium: The Stanford Prison Experiment—Enduring Lessons 40 Years Later," American Psychological Association Annual Convention, Washington, DC, August.

"The Dangerous Overuse of Solitary Confinement: Pervasive Human Rights Violations in Prisons, Jails, and Other Places of Detention" Panel, United Nations, New York, New York, October.

"Criminal Justice Reform: Issues and Recommendation," United States Congress, Washington, DC, November.

2010 "The Hardening of Prison Conditions," Opening Address, "The Imprisoned" Arthur Liman Colloquium Public Interest Series, Yale Law School, New Haven, CN, March.

"Desensitization to Inhumane Treatment: The Pitfalls of Prison Work," panel presentation at "The Imprisoned" Arthur Liman Colloquium Public Interest Series, Yale Law School, New Haven, CN, March.

"Mental Ill Health in Immigration Detention," Department of Homeland Security/DOJ Office for Civil Rights and Civil Liberties, Washington, DC, September.

2009 "Counting Casualties in the War on Prisoners," Keynote Address, at "The Road to Prison Reform: Treating the Causes and Conditions of Our Overburdened System," University of Connecticut Law School, Hartford, CN, February.

"Defining the Problem in California's Prison Crisis: Overcrowding and Its Consequences," California Correctional Crisis Conference," Hastings Law School, San Francisco, CA, March.

2008 "Prisonization and Contemporary Conditions of Confinement," Keynote Address, Women Defenders Association, Boalt Law School, University of California, November.

"Media Criminology and the Empathic Divide: The Continuing Significance of Race in Capital Trials," Invited Address, Media, Race, and the Death Penalty Conference, DePaul University School of Law, Chicago, IL, March.

"The State of the Prisons in California," Invited Opening Address, Confronting the Crisis: Current State Initiatives and Lasting Solutions for California's Prison Conditions Conference, University of San Francisco School of Law, San Francisco, CA, March.

"Mass Incarceration and Its Effects on American Society," Invited Opening Address, Behind the Walls Prison Law Symposium, University of California Davis School of Law, Davis, CA, March.

2007 "The Psychology of Imprisonment: How Prison Conditions Affect

Prisoners and Correctional Officers," United States Department of Justice, National Institute of Corrections Management Training for "Correctional Excellence" Course, Denver, CO, May.

"Statement on Psychologists, Detention, and Torture," Invited Address, American Psychological Association Annual Convention, San Francisco, CA, August.

"Prisoners of Isolation," Invited Address, University of Indiana Law School, Indianapolis, IN, October.

"Mitigation in Three Strikes Cases," Stanford Law School, Palo Alto, CA, September.

"The Psychology of Imprisonment," Occidental College, Los Angeles, CA, November.

2006 "Mitigation and Social Histories in Death Penalty Cases," Ninth Circuit Federal Capital Case Committee, Seattle, WA, May.

"The Crisis in the Prisons: Using Psychology to Understand and Improve Prison Conditions," Invited Keynote Address, Psi Chi (Undergraduate Psychology Honor Society) Research Conference, San Francisco, CA, May.

"Exoneration and 'Wrongful Condemnation': Why Juries Sentence to Death When Life is the Proper Verdict," Faces of Innocence Conference, UCLA Law School, April.

"The Continuing Effects of Imprisonment: Implications for Families and Communities," Research and Practice Symposium on Incarceration and Marriage, United States Department of Health and Human Services, Washington, DC, April.

"Ordinary People, Extraordinary Acts," National Guantanamo Teach In, Seton Hall School of Law, Newark, NJ, October.

"The Next Generation of Death Penalty Research," Invited Address, State University of New York, School of Criminal Justice, Albany, NY, October.

2005 "The 'Design' of the System of Death Sentencing: Systemic Forms of 'Moral Disengagement in the Administration of Capital Punishment, Scholar-in-Residence, invited address, Center for Social Justice, Boalt Hall School of Law (Berkeley), March.

"Humane Treatment for Asylum Seekers in U.S. Detention Centers," United States House of Representatives, Washington, DC, March.

"Prisonworld: What Overincarceration Has Done to Prisoners and the Rest of Us," Scholar-in-Residence, invited address, Center for Social Justice, Boalt Hall School of Law (Berkeley), March.

"Prison Conditions and Their Psychological Effects on Prisoners," European Association for Psychology and Law, Vilnius, Lithuania, July.

2004 "Recognizing the Adverse Psychological Effects of Incarceration, With Special Attention to Solitary-Type Confinement and Other Forms of 'Ill-Treatment' in Detention," International Committee of the Red Cross, Training Program for Detention Monitors, Geneva, Switzerland, November.

"Prison Conditions in Post-"War on Crime" Era: Coming to Terms with the Continuing Pains of Imprisonment," Boalt Law School Conference, After the War on Crime: Race, Democracy, and a New Reconstruction, Berkeley, CA, October.

"Cruel and Unusual? The United States Prison System at the Start of the 21st Century," Invited speaker, Siebel Scholars Convocation, University of Illinois, Urbana, IL, October.

"The Social Historical Roots of Violence: Introducing Life Narratives into Capital Sentencing Procedures," Invited Symposium, XXVIII International Congress of Psychology, Beijing, China, August.

"Death by Design: Capital Punishment as a Social Psychological System," Division 41 (Psychology and Law) Invited Address, American Psychological Association Annual Convention, Honolulu, HI, July.

"The Psychology of Imprisonment and the Lessons of Abu Ghraib," Commonwealth Club Public Interest Lecture Series, San Francisco, May.

"Restructuring Prisons and Restructuring Prison Reform," Yale Law School Conference on the Current Status of Prison Litigation in the United States, New Haven, CN, May.

"The Effects of Prison Conditions on Prisoners and Guards: Using Psychological Theory and Data to Understand Prison Behavior," United States Department of Justice, National Institute of Corrections Management Training Course, Denver, CO, May.

"The Contextual Revolution in Psychology and the Question of Prison Effects: What We Know about How Prison Affects Prisoners and Guards," Cambridge University, Cambridge, England, April.

"Death Penalty Attitudes, Death Qualification, and Juror Instructional Comprehension," American Psychology-Law Society, Annual Conference, Scottsdale, AZ, March.

2003 "Crossing the Empathic Divide: Race Factors in Death Penalty Decisionmaking," DePaul Law School Symposium on Race and the Death Penalty in the United States, Chicago, October.

"Supermax Prisons and the Prison Reform Paradigm," PACE Law School Conference on Prison Reform Revisited: The Unfinished Agenda, New York, October.

"Mental Health Issues in Supermax Confinement," European Psychology and Law Conference, University of Edinburgh, Scotland, July.

"Roundtable on Capital Punishment in the United States: The Key Psychological Issues," European Psychology and Law Conference, University of Edinburgh, Scotland, July.

"Psychology and Legal Change: Taking Stock," European Psychology and Law Conference, University of Edinburgh, Scotland, July.

"Economic Justice and Criminal Justice: Social Welfare and Social Control," Society for the Study of Social Issues Conference, January.

"Race, Gender, and Class Issues in the Criminal Justice System," Center for Justice, Tolerance & Community and Barrios Unidos Conference, March.

2002 "The Psychological Effects of Imprisonment: Prisonization and Beyond." Joint Urban Institute and United States Department of Health and Human Services Conference on "From Prison to Home." Washington, DC, January.

"On the Nature of Mitigation: Current Research on Capital Jury Decisionmaking." American Psychology and Law Society, Mid-Winter Meetings, Austin, Texas, March.

"Prison Conditions and Death Row Confinement." New York Bar Association, New York City, June.

2001 "Supermax and Solitary Confinement: The State of the Research and the State of the Prisons." Best Practices and Human Rights in Supermax Prisons: A Dialogue. Conference sponsored by University of Washington and the Washington Department of Corrections, Seattle, September.

"Mental Health in Supermax: On Psychological Distress and Institutional Care." Best Practices and Human Rights in Supermax Prisons: A Dialogue. Conference sponsored by University of Washington and the Washington Department of Corrections, Seattle, September.

"On the Nature of Mitigation: Research Results and Trial Process and Outcomes." Boalt Hall School of Law, University of California, Berkeley, August.

"Toward an Integrated Theory of Mitigation." American Psychological Association Annual Convention, San Francisco, CA, August.

Discussant: "Constructing Class Identities—The Impact of Educational Experiences." American Psychological Association Annual Convention, San Francisco, CA, August.

"The Rise of Carceral Consciousness." American Psychological Association Annual Convention, San Francisco, CA, August.

2000 "On the Nature of Mitigation: Countering Generic Myths in Death Penalty Decisionmaking," City University of New York Second International Advances in Qualitative Psychology Conference, March.

"Why Has U.S. Prison Policy Gone From Bad to Worse? Insights From the Stanford Prison Study and Beyond," Claremont Conference on Women, Prisons, and Criminal Injustice, March.

"The Use of Social Histories in Capital Litigation," Yale Law School, April.

"Debunking Myths About Capital Violence," Georgetown Law School, April.

"Research on Capital Jury Decisionmaking: New Data on Juror Comprehension and the Nature of Mitigation," Society for Study of Social Issues Convention, Minneapolis, June.

"Crime and Punishment: Where Do We Go From Here?" Division 41 Invited Symposium, "Beyond the Boundaries: Where Should Psychology and Law Be Taking Us?" American Psychological Association Annual Convention, Washington, DC, August.

1999 "Psychology and the State of U.S. Prisons at the Millennium," American Psychological Association Annual Convention, Boston, MA, August.

"Spreading Prison Pain: On the Worldwide Movement Towards Incarcerative Social Control," Joint American Psychology-Law Society/European Association of Psychology and Law Conference, Dublin, Ireland, July.

1998 "Prison Conditions and Prisoner Mental Health," Beyond the Prison Industrial Complex Conference, University of California, Berkeley, September.

"The State of US Prisons: A Conversation," International Congress of Applied Psychology, San Francisco, CA, August.

"Deathwork: Capital Punishment as a Social Psychological System," Invited SPPSI Address, American Psychological Association Annual Convention, San Francisco, CA, August.

"The Use and Misuse of Psychology in Justice Studies: Psychology and Legal Change: What Happened to Justice?," (panelist), American Psychological Association Annual Convention, San Francisco, CA, August.

"Twenty Five Years of American Corrections: Past and Future," American Psychology and Law Society, Redondo Beach, CA, March.

1997 "Deconstructing the Death Penalty," School of Justice Studies, Arizona State University, Tempe, AZ, October.

"Mitigation and the Study of Lives," Invited Address to Division 41 (Psychology and Law), American Psychological Association Annual Convention, Chicago, August.

1996 "The Stanford Prison Experiment and 25 Years of American Prison Policy," American Psychological Association Annual Convention, Toronto, August.

1995 "Looking Closely at the Death Penalty: Public Stereotypes and Capital Punishment," Invited Address, Arizona State University College of Public Programs series on Free Speech, Affirmative Action and Multiculturalism, Tempe, AZ, April.

"Race and the Flaws of the Meritocratic Vision," Invited Address, Arizona State University College of Public Programs series on Free Speech, Affirmative Action and Multiculturalism, Tempe, AZ, April.

"Taking Capital Jurors Seriously," Invited Address, National Conference on Juries and the Death Penalty, Indiana Law School, Bloomington, February.

1994 "Mitigation and the Social Genetics of Violence: Childhood Treatment and Adult Criminality," Invited Address, Conference on the Capital Punishment, Santa Clara Law School, October, Santa Clara.

1992 "Social Science and the Death Penalty," Chair and Discussant, American Psychological Association Annual Convention, San Francisco, CA, August.

1991 "Capital Jury Decisionmaking," Invited panelist, American Psychological Association Annual Convention, Atlanta, GA, August.

1990 "Racial Discrimination in Death Penalty Cases," Invited presentation, NAACP Legal Defense Fund Conference on Capital Litigation, August, Airlie, VA.

1989 "Psychology and Legal Change: The Impact of a Decade," Invited Address to Division 41 (Psychology and Law), American

Psychological Association Annual Convention, New Orleans, LA., August.

"Judicial Remedies to Pretrial Prejudice," Law & Society Association Annual Meeting, Madison, WI, June.

"The Social Psychology of Police Interrogation Techniques" (with R. Liebowitz), Law & Society Association Annual Meeting, Madison, WI, June.

1987 "The Fourteenth Amendment and Symbolic Legality: Let Them Eat Due Process," APA Annual Convention, New York, N.Y. August.

"The Nature and Function of Prison in the United States and Mexico: A Preliminary Comparison," InterAmerican Congress of Psychology, Havana, Cuba, July.

1986 Chair, Division 41 Invited Address and "Commentary on the Execution Ritual," APA Annual Convention, Washington, D.C., August.

"Capital Punishment," Invited Address, National Association of Criminal Defense Lawyers Annual Convention, Monterey, CA, August.

1985 "The Role of Law in Graduate Social Science Programs" and "Current Directions in Death Qualification Research," American Society of Criminology, San Diego, CA, November.

"The State of the Prisons: What's Happened to 'Justice' in the '70s and '80s?" Invited Address to Division 41 (Psychology and Law); APA Annual Convention, Los Angeles, CA, August.

1983 "The Role of Social Science in Death Penalty Litigation." Invited Address in National College of Criminal Defense Death Penalty Conference, Indianapolis, IN, September.

1982 "Psychology in the Court: Social Science Data and Legal Decision-Making." Invited Plenary Address, International Conference on Psychology and Law, University College, Swansea, Wales, July.

1982 "Paradigms in Conflict: Contrasting Methods and Styles of Psychology and Law." Invited Address, Social Science Research Council, Conference on Psychology and Law, Wolfson College, Oxford University, March.

1982 "Law and Psychology: Conflicts in Professional Roles." Invited paper, Western Psychological Association Annual Meeting, April.

1980 "Using Psychology in Test Case Litigation," panelist, American Psychological Association Annual Convention, Montreal, Canada, September.

"On the Selection of Capital Juries: The Biasing Effects of Death Qualification." Paper presented at the Interdisciplinary Conference on Capital Punishment. Georgia State University, Atlanta, GA, April.

"Diminished Capacity and Imprisonment: The Legal and Psychological Issues," Proceedings of the American Trial Lawyers Association, Mid-Winter Meeting, January.

1975 "Social Change and the Ideology of Individualism in Psychology and Law." Paper presented at the Western Psychological Association Annual Meeting, April.

SERVICE TO STAFF OR EDITORIAL BOARDS OF FOUNDATIONS, SCHOLARLY JOURNALS OR PRESSES

2016-present Editorial Consultant, Translational Issues in Psychological Science.

2015-present Editorial Consultant, Criminal Justice Review.

2014-present Editorial Board Member, Law and Social Inquiry.

2013-present Editorial Consultant, Criminal Justice and Behavior.

2012-present Editorial Consultant, Law and Society Review.

2011-present Editorial Consultant, Social Psychological and Personality Science.

2008-present Editorial Consultant, New England Journal of Medicine.

2007-present Editorial Board Member, Correctional Mental Health Reporter.

2007-present Editorial Board Member, Journal of Offender Behavior and Rehabilitation.

2004-present Editorial Board Member, American Psychology and Law Society Book Series, Oxford University Press.

2000-2003 Reviewer, Society for the Study of Social Issues Grants-in-Aid Program.

2000-present Editorial Board Member, ASAP (on-line journal of the Society for the Study of Social Issues)

1997-present Editorial Board Member, Psychology, Public Policy, and Law

1991 Editorial Consultant, Brooks/Cole Publishing

1989 Editorial Consultant, Journal of Personality and Social Psychology

1988- Editorial Consultant, American Psychologist

1985 Editorial Consultant, American Bar Foundation Research Journal

1985-2006 Law and Human Behavior, Editorial Board Member

1985 Editorial Consultant, Columbia University Press

1985 Editorial Consultant, Law and Social Inquiry

1980-present Reviewer, National Science Foundation

1997 Reviewer, National Institutes of Mental Health

1980-present Editorial Consultant, Law and Society Review

1979-1985 Editorial Consultant, Law and Human Behavior

1997-present Editorial Consultant, Legal and Criminological Psychology

1993-present Psychology, Public Policy, and Law, Editorial Consultant

GOVERNMENTAL, LEGAL AND CRIMINAL JUSTICE CONSULTING

Training Consultant, Palo Alto Police Department, 1973-1974.

Evaluation Consultant, San Mateo County Sheriff's Department, 1974.

Design and Training Consultant to Napa County Board of Supervisors, County Sheriff's Department (county jail), 1974.

Training Consultation, California Department of Corrections, 1974.

Consultant to California Legislature Select Committee in Criminal Justice, 1974, 1980-1981 (effects of prison conditions, evaluation of proposed prison legislation).

Reviewer, National Science Foundation (Law and Social Science, Research Applied to National Needs Programs), 1978-present.

Consultant, Santa Clara County Board of Supervisors, 1980 (effects of jail overcrowding, evaluation of county criminal justice policy).

Consultant to Packard Foundation, 1981 (evaluation of inmate counseling and guard training programs at San Quentin and Soledad prisons).

Member, San Francisco Foundation Criminal Justice Task Force, 1980-1982 (corrections expert).

Consultant to NAACP Legal Defense Fund, 1982- present (expert witness, case evaluation, attorney training).

Faculty, National Judicial College, 1980-1983.

Consultant to Public Advocates, Inc., 1983-1986 (public interest litigation).

Consultant to California Child, Youth, Family Coalition, 1981-82 (evaluation of proposed juvenile justice legislation).

Consultant to California Senate Office of Research, 1982 (evaluation of causes and consequences of overcrowding in California Youth Authority facilities).

Consultant, New Mexico State Public Defender, 1980-1983 (investigation of causes of February, 1980 prison riot).

Consultant, California State Supreme Court, 1983 (evaluation of county jail conditions).

Member, California State Bar Committee on Standards in Prisons and Jails, 1983.

Consultant, California Legislature Joint Committee on Prison Construction and Operations, 1985.

Consultant, United States Bureau of Prisons and United States Department of the Interior (Prison History, Conditions of Confinement Exhibition, Alcatraz Island), 1989-1991.

Consultant to United States Department of Justice, 1980-1990 (evaluation of institutional conditions).

Consultant to California Judicial Council (judicial training programs), 2000.

Consultant to American Bar Association/American Association for Advancement of Science Task Force on Forensic Standards for Scientific Evidence, 2000.

Invited Participant, White House Forum on the Uses of Science and Technology to Improve Crime and Prison Policy, 2000.

Member, Joint Legislative/California Department of Corrections Task Force on Violence, 2001.

Consultant, United States Department of Health & Human Services/Urban Institute, "Effects of Incarceration on Children, Families, and Low-Income Communities" Project, 2002.

Detention Consultant, United States Commission on International Religious Freedom (USCRIF). Evaluation of Immigration and Naturalization Service Detention Facilities, July, 2004-present.

Consultant, International Committee of the Red Cross, Geneva, Switzerland, Consultant on international conditions of confinement.

Member, Institutional Research External Review Panel, California Department of Corrections, November, 2004-2008.

Consultant, United States Department of Health & Human Services on programs designed to enhance post-prison success and community reintegration, 2006.

Consultant/Witness, U.S. House of Representatives, Judiciary Committee, Evaluation of legislative and budgetary proposals concerning the detention of aliens, February-March, 2005.

Invited Expert Witness to National Commission on Safety and Abuse in America's Prisons (Nicholas Katzenbach, Chair); Newark, New Jersey, July 19-20, 2005.

Testimony to the United States Senate, Judiciary Subcommittee on the Constitution, Civil Rights, and Property Rights (Senators Brownback and Feingold, co-chairs), Hearing on "An Examination of the Death Penalty in the United States," February 7, 2006.

National Council of Crime and Delinquency "Sentencing and Correctional Policy Task Force," member providing written policy recommendations to the California legislature concerning overcrowding crisis in the California Department of Corrections and Rehabilitation.

Trainer/Instructor, Federal Bureau of Prisons and United States Department of Justice, "Correctional Excellence" Program, providing instruction concerning conditions of confinement and psychological stresses of living and working in correctional environments to mid-level management corrections professionals, May, 2004-2008.

Invited Expert Witness, California Commission on the Fair Administration of Justice, Public Hearing, Santa Clara University, March 28, 2008.

Invited Participant, Department of Homeland Security, Mental Health Effects of Detention and Isolation, 2010.

Invited Witness, Before the California Assembly Committee on Public Safety, August 23, 2011.

Consultant, "Reforming the Criminal Justice System in the United States" Joint Working Group with Senator James Webb and Congressional Staffs, 2011 Developing National Criminal Justice Commission Legislation.

Invited Participant, United Nations, Forum with United Nations Special Rapporteur on Torture Concerning the Overuse of Solitary Confinement, New York, October, 2011.

Invited Witness, Before United States Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights Hearing on Solitary Confinement, June 19, 2012.

Member, National Academy of Sciences Committee to Study the Causes and Consequences of the High Rate of Incarceration in the United States, 2012-2014.

Member, National Academy of Sciences Briefing Group, briefed media and public officials at Pew Research Center, Congressional staff, and White House staff

concerning policy implications of The Growth of Incarceration in the United States: Exploring the Causes and Consequences (2014), April 30-May 1.

Consultant to United States Department of Justice and White House Domestic Policy Council on formulation of federal policy concerning use of segregation confinement, 2015.

PRISON AND JAIL CONDITIONS EVALUATIONS AND LITIGATION

Hoptowit v. Ray [United States District Court, Eastern District of Washington, 1980; 682 F.2d 1237 (9th Cir. 1982)]. Evaluation of psychological effects of conditions of confinement at Washington State Penitentiary at Walla Walla for United States Department of Justice.

Wilson v. Brown (Marin Country Superior Court; September, 1982, Justice Burke). Evaluation of effects of overcrowding on San Quentin mainline inmates.

Thompson v. Enomoto (United States District Court, Northern District of California, Judge Stanley Weigel, 1982 and continuing). Evaluation of conditions of confinement on Condemned Row, San Quentin Prison.

Toussaint v. McCarthy [United States District Court, Northern District of California, Judge Stanley Weigel, 553 F. Supp. 1365 (1983); 722 F. 2d 1490 (9th Cir. 1984) 711 F. Supp. 536 (1989)]. Evaluation of psychological effects of conditions of confinement in lockup units at DVI, Folsom, San Quentin, and Soledad.

In re Priest (Proceeding by special appointment of the California Supreme Court, Judge Spurgeon Avakian, 1983). Evaluation of conditions of confinement in Lake County Jail.

Ruiz v. Estelle [United States District Court, Southern District of Texas, Judge William Justice, 503 F. Supp. 1265 (1980)]. Evaluation of effects of overcrowding in the Texas prison system, 1983-1985.

In re Atascadero State Hospital (Civil Rights of Institutionalized Persons Act of 1980 action). Evaluation of conditions of confinement and nature of patient care at ASH for United States Department of Justice, 1983-1984.

In re Rock (Monterey County Superior Court 1984). Appointed to evaluate conditions of confinement in Soledad State Prison in Soledad, California.

In re Mackey (Sacramento County Superior Court, 1985). Appointed to evaluate conditions of confinement at Folsom State Prison mainline housing units.

Bruscino v. Carlson (United States District Court, Southern District of Illinois 1984 1985). Evaluation of conditions of confinement at the United States Penitentiary at Marion, Illinois [654 F. Supp. 609 (1987); 854 F.2d 162 (7th Cir. 1988)].

Dohner v. McCarthy [United States District Court, Central District of California, 1984-1985; 636 F. Supp. 408 (1985)]. Evaluation of conditions of confinement at California Men's Colony, San Luis Obispo.

Invited Testimony before Joint Legislative Committee on Prison Construction and Operations hearings on the causes and consequences of violence at Folsom Prison, June, 1985.

Stewart v. Gates [United States District Court, 1987]. Evaluation of conditions of confinement in psychiatric and medical units in Orange County Main Jail, Santa Ana, California.

Duran v. Anaya (United States District Court, 1987-1988). Evaluation of conditions of confinement in the Penitentiary of New Mexico, Santa Fe, New Mexico [Duran v. Anaya, No. 77-721 (D. N.M. July 17, 1980); Duran v. King, No. 77-721 (D. N.M. March 15, 1984)].

Gates v. Deukmejian (United States District Court, Eastern District of California, 1989). Evaluation of conditions of confinement at California Medical Facility, Vacaville, California.

Kozeak v. McCarthy (San Bernardino Superior Court, 1990). Evaluation of conditions of confinement at California Institution for Women, Frontera, California.

Coleman v. Gomez (United States District Court, Eastern District of California, 1992-3; Magistrate Moulds, Chief Judge Lawrence Karlton, 912 F. Supp. 1282 (1995). Evaluation of study of quality of mental health care in California prison system, special mental health needs at Pelican Bay State Prison.

Madrid v. Gomez (United States District Court, Northern District of California, 1993, District Judge Thelton Henderson, 889 F. Supp. 1146 (N.D. Cal. 1995). Evaluation of conditions of confinement and psychological consequences of isolation in Security Housing Unit at Pelican Bay State Prison, Crescent City, California.

Clark v. Wilson, (United States District Court, Northern District of California, 1998, District Judge Fern Smith, No. C-96-1486 FMS), evaluation of screening

procedures to identify and treatment of developmentally disabled prisoners in California Department of Corrections.

Turay v. Seling [United States District Court, Western District of Washington (1998)]. Evaluation of Conditions of Confinement-Related Issues in Special Commitment Center at McNeil Island Correctional Center.

In re: The Commitment of Durden, Jackson, Leach, & Wilson. [Circuit Court, Palm Beach County, Florida (1999).] Evaluation of Conditions of Confinement in Martin Treatment Facility.

Ruiz v. Johnson [United States District Court, Southern District of Texas, District Judge William Wayne Justice, 37 F. Supp. 2d 855 (SD Texas 1999)]. Evaluation of current conditions of confinement, especially in security housing or "high security" units.

Osterback v. Moore (United States District Court, Southern District of Florida (97-2806-CIV-MORENO) (2001) [see, Osterback v. Moore, 531 U.S. 1172 (2001)]. Evaluation of Close Management Units and Conditions in the Florida Department of Corrections.

Valdivia v. Davis (United States District Court, Eastern District of California, 2002). Evaluation of due process protections afforded mentally ill and developmentally disabled parolees in parole revocation process.

Ayers v. Perry (United States District Court, New Mexico, 2003). Evaluation of conditions of confinement and mental health services in New Mexico Department of Corrections "special controls facilities."

Disability Law Center v. Massachusetts Department of Corrections (Federal District Court, Massachusetts, 2007). Evaluation of conditions of confinement and treatment of mentally ill prisoners in disciplinary lockup and segregation units.

Plata/Coleman v. Schwarzenegger (Ninth Circuit Court of Appeals, Three-Judge Panel, 2008). Evaluation of conditions of confinement, effects of overcrowding on provision of medical and mental health care in California Department of Corrections and Rehabilitation. [See Brown v. Plata, 131 S.Ct. 1910 (2011).]

# Exhibit 2

Professor Craig Haney: Statement of Compensation and
Trial and Deposition Testimony Over Past Four Years

Compensation:

I am being compensated by the Southern Poverty Law Center at an hourly rate of $250 for all case-related work, a rate of $125 for non-working travel time (to and from case-related destinations), and $350 for case-related deposition and trial testimony.

Trial, Hearing, and Deposition Testimony:

2012: United States v. Richardson (federal), trial testimony

People v. Gatica (state), trial testimony

United States Senate Judiciary Committee (federal), hearing testimony

2013: United States v. Northington (federal), trial testimony.

United States v. McCluskey (federal), trial testimony.

Mitchell v. Cate (state), deposition testimony.

2014 United States v. Williams (federal), trial testimony.

State v. Kleppinger (federal), hearing testimony.

In re Albert Carreon (federal), hearing testimony.

Sardakowski v. Clements (federal), deposition testimony.

Parsons v. Ryan (federal), deposition testimony.

2015 State v. Lambright (state), trial testimony.

Wilkerson v. Stalder (federal), deposition testimony.

2016 No trial, hearing, or deposition testimony to July 4, 2016.

# EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

| | | |
|---|---|---|
| JOSHUA DUNN, ET AL., | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | Civil Action Number: |
| v. | ) | |
| | ) | 2:14-cv-00601-MHT-TFM |
| JEFFERSON DUNN, ET AL., | ) | |
| | ) | |
| Defendants. | ) | |

## MATERIALS

In forming my opinions in this case, I relied on my observations during inspections of ADOC facilities, interviews with over 100 prisoners currently housed in ADOC, and the materials listed below.

DEPOSITION TRANSCRIPTS

- BRENDA FIELDS
- GLODYS ST-PHARD, M.D.
- JOSHUA DUNN
- LASANDRA BUCHANANT
- LESLEIGH DODD
- LYNN BROWN
- ROBERT HUNTER, M.D.
- SCOTT HOLMES
- SHARON TRIMBLE
- TERESA HOUSER – 11.20.2015
- TERESA HOUSER – 4.22.2016
- RUTH NAGLICH – 12.7.2015
- RUTH NAGLICH – 4.7.2016
- CHARLES WOODLEY, Ph.D.
- DOROTHY COOGAN
- CHRISTOPHER JACKSON
- RICHARD BUSINELLE

- ANNA DAVIS-WALKER – 2.12.2016
- ANNA DAVIS-WALKER – 3.1.2016

ADDITIONAL DOCUMENTS

- BIBB SEG ROSTER MARCH 11
- BULLOCK ROSTER – 3.11.16
- EASTERLING SEG ROSTER – 3.11.16
- HOLMAN ROSTER – 3.11.16
- KILBY SEG ROSTER – 3.11.16
- MHM – DONALDSON 2013 ADOC045441-045515
- MHM OCCURRENCES
- MHM BULLOCK CRISIS CELL STATS
- MHM DONALDSON CRISIS CELL LOGS AUDITS BY MHM CORP TEAM
- MHM PRODUCTION THIRD PRODUCTION – PRODUCED ON 9.30.2015
- MHM COMPLETED SUICIDES
- MHM Chart Audits by Regional Office
- MHM CQI Meeting Minutes
- MHM Clinical Contract Compliance Review Report
- MHM Death Review Reports
- MHM Training Outlines and Powerpoints
- MHM 2015 ADOC Clinical Contract Compliance Review Report – February 2016 (MHM / Alabama Department of Corrections Monthly Operations Report)
- Incident Report – Braggs – Hamilton
- Photo from March Site Inspection at Bullock
- MHM Database from Staton
- MHM Database from Kilby
- MHM Database from Holman
- MHM Database from Fountain
- MHM Database of Caseload
- ADOC Monthly Operations Report February 2016

MHM PRIVILEGE ORDER

- Doc. 318 – Order – 1.27.2016

**EXHIBIT 4**

# APPENDIX

This Appendix contains summaries of the numerous cell-front and confidential individual interviews that I conducted in various ADOC facilities in conjunction with my analysis of the nature and effects of conditions of confinement and mental health care services in the Alabama prison system. The interviews are presented in the order in which they were conducted, and all of the substantive, relevant interviews are summarized in this document (i.e., no prisoner who shared substantive, relevant information has been omitted from these summaries).

As I noted in my Report, the information is notable for its shocking content (i.e., the accounts provided by the prisoners provide evidence of widespread, deep-seated, and very serious deliberate indifference, neglect, and mistreatment) and for its remarkable consistency (i.e., prisoner after prisoner, in various ADOC facilities, provided similar if not identical corroborating accounts and descriptions of the neglect and abuse to which they and others were subjected).

**JULIA TUTWILER PRISON**

**Brief Interviews**

1. During my tour of Tutwiler, I entered one of the general population dorms and randomly selected several women to interview. They each reported getting no more than pro forma visits from the mental health staff. The counselors, they said, "just ask me how I'm doing" [Ms. X.J.] and they just "ask if you're OK, they don't know you" [Ms. X.D.L.]. Some said their contact was even more infrequent—"I haven't had MH counseling for 2 months" [Ms. E.Z.].

2. The women in the Segregation Unit voiced similar complaints when I spoke with them cell-front, which ranged from "we get treated terribly back here; we get no help from staff" [Ms. H.A.] to there is "nothing to do, you are stuck here; it's empty, you are existing." [Ms. H.L.I.] Some women voiced general complaints about the way the unit itself was being run, including the fact that the prisoners are made to roll up their mattresses all day (but have nothing to do in their cells during that time) and are required to have their hands and feet shackled during the 45 minutes or so that they are allowed outside (in the small fenced cages where they are allowed "yard" time). In addition, the women were very upset that their mental health problems were being neglected: "I have to scream, cut up to make them see me" [Ms. U.I.] and "to see our counselors we have to usually declare a 'crisis'" [Ms. T.L.Z.]. These concerns were repeated and elaborated on in the more in-depth interviews I conducted.

**Confidential Interviews**

3. While I was at Tutwiler, I conducted a series of eight confidential interviews in a private setting at the prison. Except for one of the women (selected randomly from my tour the day before), all of the interviewees were from the Segregation Unit, including

several with whom I had talked cell-front the day before. They each voiced a series of serious complaints, and several talked movingly about how their experience at the prison—and especially in Segregation—had adversely affected their already fragile mental health. Ms. F.D.Z. told me that mental illness runs in her family, that she had attempted suicide in 2007, had been diagnosed with bi-polar disorder, and that she is now taking Risperdal and other medications at the prison. Although she said that the staff had treated her "okay," she told me Segregation was "the worst" and that it is "driving me crazy, we are behind the wall all the time."

4. Ms. H.L.I. complained at length about her mental health care. She told me that she "never had mental health problems before" being put in Segregation, where, she said, she "felt I was losing my mind, hearing voices." Ms. H.L.I. complained that staff can be very dismissive of the women's mental health problems. She told me about telling staff that she was having a crisis, and them responding, "oh, stop it." She went on to say that "we ask to see docs in Seg but they don't come see us. Lots of times nurses don't come or take care of us. You can't get health care." She said that she had seen her counselor only once since being in Segregation. That time the counselor told her she would be seen once a week, but, "it never happened—I see her walk by my cell, she just gives me a puzzle, I ask for an appointment but I don't get it."

5. Ms. I.M.R. voiced similar complaints about the lack of meaningful mental health treatment. To illustrate, she told me a story about another inmate, Ms. S.R.L., who she said had made a serious attempt to commit suicide a little more than a month earlier, but who "had been begging for mental health care" beforehand. This inmate was apparently someone "everybody knew . . . needed help" but was not getting any, until she "finally tried to hang herself." Ms. I.M.R. showed me where she cut her own wrists a

few years ago. She told me that she was currently taking Prozac and Lithium for her bi-polar and anxiety disorder, but she also said that she had not seen her counselor more than three times or so in the last year.

6. Another inmate, Ms. O.E.J., explained to me that she had a very long psychiatric history that dated back to when she was nine years old, and included receiving in-patient psychiatric treatment in the freeworld. She said that she had reacted badly to being housed in Segregation, and had three prior suicide attempts when she was there. Ms. O.E.J. told me that her struggle with self harm and suicidality was an ongoing problem for her, but that she has gotten little or no mental health treatment or care for it: "I tell them I want to cut up and sometimes kill myself. They just tell me to cope better." She said that her experience as a patient on the mental health caseload has been very problematic—the counselors "all shuffle around, as soon as they get to know you, and you them, they are gone. You never really do any therapy—it is a big cycle of nothingness—you are just a piece of paper to them." Despite her history of suicide attempts and self harm (which she said began at age 11), and the fact that she had been given Haldol shots in the past and said she currently takes Remeron and Trazodone, Ms. O.E.J. said that she sees a counselor no more than once a month and that mental health "rounds" in Segregation occur only two times a week. Even then, she said, they consist of no more than mental health staff asking "are you okay?" She said, "even if you say 'no,' they keep walking, they do no follow-up."

7. Ms. Q.V.Q. voiced similar complaints. She said the Segregation Unit had become harsher over the last few years—for example, the women are no longer allowed to go to the outdoor yard with another prisoner, and when they do go to the yard, they are kept in shackles and handcuffs (something she said deters her and others from going). She,

too, talked about the poor quality of mental health care. Despite the fact that she had a long history of self-harm (dating back to age 15), and had been on suicide watch in prison (as recently as this year), she complained about the rotating mental health staff and the inconsistent nature of the treatment she got: "since 2010 I've had 4 or 5 counselors, and had 4 different kinds of meds." In addition to the turnover, she said "it's hard to see mental health; they want you to be homicidal or suicidal." Like many mentally ill prisoners, Ms. Q.V.Q. was having a very difficult time adjusting to Segregation: "I asked my counselor, please don't send me back to Segregation. I'm not ready. Things close in on you in Seg. So I cut myself. [They] took me to SU [the Stabilization Unit]. It's better there than Seg. It allows you to just sleep and not be bothered." However, she had been placed back in Segregation at the time I interviewed her.

8. Ms. U.R.I. told me that she had been diagnosed with PTSD as well as some "other" psychiatric conditions she could not remember but said were described in her file. She said that medical and mental health care at Tutwiler are "awful" and that "they just want to lock you up." Because the mental health staff "doesn't listen to you, just judge you," she said, "we learn not to show our emotions or talk to them." She said that in the past, when she has told them she needed help, she was ignored, which is how she said she ended up in Segregation: "I told them I needed help, but nobody helped me blow off steam, so I got in trouble and got locked up [in Segregation]." She said that although mental health takes her out of her cell once a month, they only "ask me if I'm OK, they don't really try to help. If I want to talk to a person, they just want to rush you along."

9. Similarly, Ms. H.M.S., the one woman I interviewed who was not from the Segregation Unit, told me that she had been a nurse in the freeworld and gotten on the mental health caseload shortly after coming to prison. She said she was suffering from PTSD from trauma that she had experienced from prior domestic violence. She also had serious medical problems that were affecting her mental state. She told me that her medical condition—she had a number of surgeries and now wears an ileostomy bag—"has caused huge mental health problems." Yet Ms. H.M.S. said that she was seen only twice by mental health staff over a five month period. She said that her counselor told her that she has 120 patients on her caseload and only a short amount of time in which to see them. Ms. H.M.S. told me: "They make you sit for hours to get a medical or mental health appointment. It's a deterrent."

**HOLMAN CORRECTIONAL FACILITY**

**Confidential Interviews**

10. Because of the restrictions that were in place during my visits to Holman, I was unable able to conduct any brief, cell-front interviews; all of my Holman interviews were confidential and conducted in the Holman visiting room. One man I interviewed, Mr. N.R.I., told me that he had been in a number of different ADOC "lockups" or Segregation units during his time in prison, but that Holman is "the worst." He said that, among other things, he had no working light in his cell, so at nighttime, his cell was completely dark. Mr. N.R.I. told me that he was traumatized when he first came to prison more than twenty years ago, and that he deteriorated psychologically. His deterioration included experiencing psychotic symptoms, and this resulted in him being placed on strong psychotropic medications (including Haldol and Thorazine). Although he continued to be prescribed a number of different psychotropic medications, he said that he had recently filed in court to discontinue them. Mr. N.R.I. said that the mental health care in ADOC has deteriorated over time. There was once a brief time when mental health counselors came and actually talked to their patients once a week. Now, he said, although mental health staff comes through the Segregation Unit three times a week now, they only come as part of the "Seg Board." Because this group includes custody staff, prisoners are unwilling to candidly discuss sensitive mental health issues.

11. Mr. N.R.I. also confirmed that the chaotic scene I had witnessed in the Holman Segregation Unit was not at all unusual: "People be yelling and screaming all night long." He told me that the man who recently committed suicide on the unit "was asking again and again" for help with his mental health problems and that, although he was taken out of the unit a few times, staff always brought him right back (one time with no

clothes on). He said that the night the suicide happened the staff had conducted no security checks and "the next morning he was hanging in his cell."

12. The second inmate I interviewed from the Holman Segregation Unit, Mr. U.A.K., also talked about the man who had recently committed suicide in the unit. Mr. U.A.K. was housed across the unit from this inmate and said that the man told staff he was suicidal and needed help, and that "he begged for mental health attention but he never got it." Mr. U.A.K. told me that he had mental health problems of his own, and had been diagnosed as schizophrenic and bi-polar, and was taking psychotropic medications in the freeworld. He said that segregation was hard to take: "All I do is sit, look out the window, walk, just try to keep my mind off of how I'm being treated, what I'm facing—people screaming and hollering all day and night—it never gets quiet in there. The way it was [when I went through earlier in the day] was as good as it gets. They cleaned up before you all got here." He also told me that the correctional staff uses pepper spray frequently in the Segregation Unit—"They did it yesterday—spray it in your cell through [the] tray slot, close the slot, walk away, come back and the man is on the floor. They did one yesterday."

13. When I returned to Holman in June 2016, I interviewed Mr. D.W.I. who told me that he did remember when I and several others had toured the Segregation Unit, in September, 2015 and that he was, in fact, asked if he would come out for an interview. However, he said he was not told who wanted to interview him or for what reason, so he declined. He went on to tell me that he had been kept in Segregation for over a year. He attributed his presence in Segregation to the "bad conditions" in the general population and the fact that, in his opinion, correctional officers who work in the dorms "don't care" about how dangerous it is there. He said that razor blades are still readily available in

the prison and that prisoners buy them from one another. Mr. D.W.I. told me that he had experienced significant trauma in his earlier life (including the murder of his father), and that he had received psychiatric care before coming to prison.

14. Mr. D.W.I. said he is on the ADOC mental health caseload and has been taking psychotropic medications since 2000. But, he said, medications were the only mental health care that he had received. Although he goes to a "medication review" every couple of months, he said that the last time he was taken out of his cell for actual mental health treatment or therapy was in 2000 when, apparently, there was some form of group therapy being conducted, at least for some of the mentally ill prisoners at Holman. However, he does not recall being taken out of his cell for treatment at any time in the nearly 16 years since then. He said, "they just don't pull you out here for mental health." He told me that a mental health staff member, Ms. Dodd, does walk through the Segregation Unit, but "you have to stop her or she just ignores you."

15. Mr. D.W.I. explained further that he had recently had a disagreement about his medications with Ms. Harvey, the C.R.N.P. who prescribes his medications, and that as a result, his medications were abruptly stopped. He said that he is at a loss to know what to do to get put back on them, even though he feels he really needs them: "I've asked and asked for my meds back but haven't gotten them." Mr. D.W.I. also told me that security and emergency responses in the Segregation Unit are "non-existent back there, they just ignore us. Guys hang up and they don't know until the next day. Guys say they are suicidal and they ignore it." He also said that the inmates in Segregation are so desperate for help that they "set fires to get some attention for their problems." He said there was a fire burning back in Segregation at that very moment—right at the time he came out for the interview.

16. I had only a brief amount of time to interview Mr. E.K., because there was such a lengthy delay in bringing him out. He told me that he was a long-term segregated prisoner who had been in some form of isolated confinement at various ADOC facilities for decades—indeed, most of his more than 40 years in prison were spent in segregated housing of one form or another. He is now confined to a wheelchair due to advanced age, cancer, and other infirmities; it was difficult for him to navigate the stairs down to the visiting area. As best I could determine, his presence in the Segregation Unit at Holman (and other facilities) was due largely to his status as a vulnerable prisoner who might be victimized by other prisoners. Mr. E.K. also corroborated what virtually all of the other Holman Segregation inmates had told me, that the unit is extremely chaotic and barely tolerable on a day-to day basis. He said that there are "people back there who burn their cells, throw feces on people, beat their door day and night" and that it is "like a mental ward back there [more] than anything else."

**EASTERLING CORRECTIONAL FACILITY**

**Confidential Interviews**

19. During my brief visit to Easterling, I conducted three confidential interviews with prisoners from the Segregation Unit. Mr. B.J.R. told me that he had required some psychiatric care as a child, but that his problems worsened in prison. He said he is currently diagnosed with bi-polar disorder and depression, and has been to the RTU at Bullock; he takes psychotropic medications (Zoloft) that he feels are helping him. He said that there are some good mental health counselors in ADOC but that they are overworked and that there are too few of them. He said he sees a mental health counselor once a month, "for 5-10 minutes—it's useless—[they] give you a puzzle and an encouraging word—too rushed." He was previously in a Suicide Watch cell and described the experience this way: "I was stripped, put in the cell shackled, with no property. For the first 40 hours I didn't even have a 'turtle suit' [the padded suicide vest that inmates on suicide watch are often required to wear]—they talked to me real rough, threw me on a mattress and left me there."

20. The second inmate, Mr. D.M.L. described having a serious and long-standing mental health history that dated back to before he entered prison. He told me that he had received mental health treatment as a child that included being put on a number of different psychotropic medications. When he entered prison, he said, he was placed directly on the mental health caseload. Other than psychotropic medications, however, he that said his mental health "treatment" has consisted of nothing more than being called out to discuss his medications every 60 or 90 days, and what he described as "walk throughs"—mental health staff members walking through the Segregation Unit—but, he said, "they don't really talk to you."

21. Finally, Mr. G.E.I. seemed very upset and very much affected by his time in Segregation. He told me that, although he had a traumatic upbringing, he did not really acknowledge his psychiatric problems until he came to prison. Although he had finally recognized that he needed mental health care, he complained that he was not getting any. He said the "mental health care is bad, I see a person once a month for maybe 10 minutes—they aren't interested in me." He explained further that, although he has asked for help, "I don't get any, all they do is come around, maybe twice a week" in the unit, and "sometimes they don't even come to your cell, just stay on the yellow line [that runs down the middle of the wide hallway]—it's meaningless." Mr. G.E.I. went on to say that he believes that his psychiatric problems are serious—that he gets angry, acts out, and hurts himself—and, although he is being given Celexa, the psychiatric problems persist. He told me: "I'm being trapped in here [Segregation]. They provoke you, you get mad, act out, then you are kept here."

**BULLOCK CORRECTIONAL FACILITY**

**Brief Cell-Front Interviews**

*Main Building*

22. I spoke to numerous prisoners cell-front in Unit B, the Segregation Unit in Bullock's main facility. Several of them complained of having been beaten by correctional officers, including Mr. M.M.I., Mr. D.T.C., and Mr. B.L.B. Another prisoner, Mr. B.Q., told me that mental health contact was very sporadic there—they "come through maybe once a week, but they usually don't even do that"—and that even then the contact they had with prisoners was cursory: "The officer says, 'mental health,' and the mental health [staff] just walk through, don't stop at your cell, just walk by, if you are breathing, you are OK." Another man, Mr. N.B.E., told me that he had been double-celled with an unstable mentally ill prisoner who was not taking his medications and kept provoking Mr. N.B.E. According to Mr. N.B.E., when the cellmate finally attacked him, Mr. N.B.E. was the one who got written up and placed in Segregation. Mr. D.L.C. said that there is a disincentive for prisoners to identify themselves as mentally ill at Bullock—"if you say you are mental health, the lieutenant or captain will jump on you." He also told me that "mental health [staff] hardly ever come through" this unit, "once or twice a month," and when they do, "they just walk through or yell from the gate, 'you all okay?'"

23. In C Dorm, one of the mental health units at Bullock that is used as a "stepdown" unit for mentally ill prisoners who are transferred from the RTU to the main facility, I spoke with Mr. E.P.Q., one of the named plaintiffs in this case, who told me he was taking psychotropic medications (Zyprexa, which is often used to treat psychosis and bi-polar disorders, and Remeron, an anti-depressant). He also volunteered that "it's all

confusing," and explained that he did not think there was any discernible logic to the programming: "the last group they called was two months ago, 'coping,' but I took [it] before—same thing." He said that he sees a mental health counselor, Ms. Wiggins, every two months or so, for no more than about "5 or 6 minutes." He also said: "There are no mental health rounds—they don't come in here, we don't see anyone." I interviewed another prisoner, Mr. L.L., in the hallway, outside the unit. Mr. L.L. was an elderly man (who looked much older than his stated 65 years), very disheveled and wearing a dirty uniform. He said that he had come back from the RTU (to this stepdown unit) and was no longer taking his medications; sadly, he was otherwise almost totally incoherent.

*RTU*

24. On the RTU side, I also conducted a brief cell-front interview with Mr. X.L.I., the man I had encountered in the window-enclosed room that the captain told me was used only for very short-term confinement. [See my Report, ¶ 68.] During the five weeks that Mr. X.L.I. estimated he had been in the "time out" cell, he had not received any programming or out-of-cell time, other than being allowed to shower. Mr. X.L.I. told me that he was on Zyprexa and Remeron, but that these medications were the only mental health care he received: "I have had no counseling, no groups, in five weeks back here." Ironically, despite the fact that he was literally living in the treatment area of the prison, he was receiving no treatment.

25. I conducted multiple cell-front interviews in the mental health Stabilization Unit, including an interview of Mr. X.B., a man whom I first saw at Holman in September, 2015, when I attempted (unsuccessfully) to interview him there. [See my Report, ¶ 51.] Mr. X.B. was in terrible shape at Bullock, living in what is essentially a very harsh "lockup" unit, housed virtually around-the-clock in an extremely disheveled cell. He told

me: "I just came off suicide watch. I'm having a hard time. Voices tell me to hurt myself—the police beat me up. I've been here since [being in the] hospital, but they keep me here." He said he had been at Holman until November, 2015 (which would have been about two months after I tried to interview him there), where he said "they treated me bad." He was on Suicide Watch for much of the last period of time he was at Holman, and then was transferred to Bullock. He had no recollection of seeing my group tour the facility in September and did not recall being asked to be interviewed. He told me he was on a very strong regimen of psychotropic medications, including Haldol, Kolonpin (sometimes used for panic disorders and to control seizures), and Vistaril. However, he said that, despite the medications, he is still bothered by voices: "The voices are real, they made me kill someone and I can't make them go away. The officers just tell me to grow up."

26. Another prisoner in the mental health Stabilization Unit, Mr. H.G.B., was equally if not more disturbed than Mr. X.B. Mr. H.G.B. was unable to maintain a coherent conversation, and continually repeated himself. He said that he was receiving Social Security Disability insurance payments before he came to prison, because of his severe psychiatric condition, and that he continues to suffer from mental illness in prison. He said, "I go in and out—I'm here and then I'm gone." Despite this, he told me that he had not been taken out of his cell for mental health treatment for about two months. I also spoke to Mr. C.B. in the same unit, who said he was on "psych observation" and was supposed to be transferred elsewhere. Mr. C.B. said he was receiving Haldol shots, but that this was the only mental health treatment that he was receiving.

## **Confidential Interviews**

*Main Building*

27. I also conducted several individual confidential interviews with inmates who had been pre-selected from the facility roster or identified in the course of the tour. The first inmate, Mr. B.Q., was very concerned about being retaliated against for talking to me.[1] He said that he had arrived at Bullock just about a year earlier and spent a brief time in the RTU (which he referred to as "the Blue Building"), and was housed in C dorm, the "stepdown" mental health unit in the main facility. He complained that the RTU "was crazy" and that it would "make you mad in your mind." He said he had taken Sinequan in prison in Florida, and Resperdol in ADOC, although he told me he did not really need it and only took medication to sleep. Although he implied that he thought he did not really have any mental health issues, he clearly did. In addition to being very incoherent during much of the interview, he told me that he had "special powers" that had gotten him in trouble in the past and said that changes in the weather were caused by the way people treat each other in places like this one. He voiced many complaints about the correctional officers who, he said, mistreat prisoners and say that they are going to "break" you. Mr. B.Q. also told me that "no mental health people" come into C Dorm, although it houses a lot of people who are in need of mental health care—"we hardly see them—they don't ever come into the unit." If you request a mental health contact, he said, "maybe you get called out, maybe not, but [if so] only for a few minutes."

28. Another inmate from C dorm, Mr. C.L.Q., told me he had been diagnosed with schizophrenia at age 12 and "was in and out of mental health care all my life," including being committed to a psychiatric hospital several times. He said he has taken a wide variety of psychotropic medications for his mental illness, including Prozac, Remeron,

[1] Another prisoner who I spoke to confidentially, Mr. U.S. appeared very fragile, nervous, and was disheveled, wearing dirty clothes. He was wary of talking, did not want to be interviewed, and said "I'm not filing against them." Similarly, another prisoner, Mr. U.S.I. alluded to his lawyers and his appeal and said he did not want to talk to us for that reason.

Thorazine, Prolixin, and Atavan. He told me that the overall treatment at Bullock had deteriorated over the last several years, including the fact that the staff, especially the correctional officers, were "unprofessional," and often threatened the prisoners. He said that he has not received any real treatment at Bullock and that his mental health counselor, Mr. Turner, who is supposed to see him every month, hardly ever does. He said Mr. Turner last called him out about four months before our interview. He said that even when he does call him out, he only spends about 5-10 minutes with him.

29. I also interviewed Mr. C.J.S., who was housed in the main facility's Segregation Unit. Mr. C.J.S. told me that he was a Vietnam veteran who had done four tours of duty and was being treated for PTSD before being arrested on his criminal case. He was placed in Segregation on "closed out" status (which, according to him, meant that he would never be released—"I'm like on death row"). He described the Segregation Unit in graphic terms, telling me that there were rats, roaches, and flies that bite you in your cell. He said that if a prisoner tells correctional officers that he is at his breaking point and cannot take it, the correctional officers "pull you out of your cell and beat you—I've seen it. A guy next to me was pulled out and beaten in the hallway with sticks, [then] sprayed with pepper spray. It happens every week or so in here." He told me that the correctional officers "treat us like animals, and even animals are treated better." Mr. C.J.S. said the Warden comes down to the Segregation Unit and tells the men "you're going to die back here." Mr. C.J.S. was getting treatment for his psychiatric problems on the street but said he had to fight hard in prison to get anything, including his medication. Mr. C.J.S. said that his medication—which he takes for PTSD, depression, and anxiety—was in essence the only treatment he got. He told me that he sees a doctor, on the television, who checks on his medications, in an interview that lasts no more than

five minutes. Other than that, his counselor sees him less than once a month, and even that is only cell-front: it "lasts a minute, 'hello, how are you doing? You alright?' then he's gone." He said he had never been taken out of his cell for an interview or a counseling session. Mr. C.J.S. said he had been incarcerated in ADOC for a long time and emphasized to me that things were getting worse rather than better. He said the prison system in Alabama has become so overcrowded that they do not have enough room for all the prisoners to sleep—people [are] sleeping on the floor, in the showers."

*RTU*

30. During my visit to Bullock, I also conducted a confidential interview with Mr. X.L.I., the man in the "time out" cell whom I had spoken to cell-front. [See my Report, ¶ 68.] He reiterated that he had not been out of the window-enclosed cell for more than a total of a few hours in the entire five weeks or so he that he had been confined in the "time out" cell located in the treatment area at Bullock (a calculation he made by adding the only out-of-cell time he was allowed—10 minute showers, three times a week). Even though Mr. X.L.I. suffers from mentally illness (he said he was diagnosed with bi-polar disorder and major depression), and is living literally in the treatment area of the prison, he said that he has received "no mental health contact" at all and that "they weren't even giving me my meds until I yelled to a psychiatrist." Moreover, he said that before he was housed in this "time-out cell," he had gone for years in ADOC without getting any real mental health treatment. The very severe form of isolation to which he was being subjected had clearly take a psychological toll—he reported suffering nearly every pathological symptom of isolated confinement, and was suffering from most of them nearly all the time.

31. I also interviewed Mr. X.B. confidentially. He corroborated a number of the things that he had said earlier during my cell-front interview with him, including that he is being given forced medications, that they do not entirely control the voices in his head, that he has long-standing and serious mental health problems (that include being sent to the ADOC mental hospital, Taylor Hardin, several times), and that he had been in the Segregation Unit at Holman for what he thought was a long time. He said he found the Holman Segregation Unit impossible to tolerate and that the entire time he was there, "nobody tried to help me." At Bullock, Mr. X.B. said he is afraid to come out of his cell. He said he does not to go to the dayroom because he would be kept in handcuffs and feels he would be vulnerable to being attacked by others. He told me that he had been placed under observation just recently because "I just tried to hang myself, and I swallowed a battery to kill myself; I hurt myself because it takes my pain away." His mental health records indicated that he had attempted suicide three times between February and my mid-March visit.

32. Another Bullock prisoner I confidentially interviewed, Mr. C.D.B., was housed in the open dorms in the RTU and told me that he had a very long psychiatric history. He said that his paranoia began as a child and continues to the present, and that he had been diagnosed with paranoid schizophrenia. He said he has had a number of psychotic breaks that resulted in being placed in Suicide Watch cells—"I've cut myself with razor blades." When he was out of prison most recently, he had been hospitalized several times for psychiatric reasons. Mr. C.D.B. said his mental health treatment while in prison, stretching over many years, consisted largely of medication and "check ins" with the doctor, without much real therapy ever taking place. Although he said there was a time—a number of years ago—when he was offered some opportunity to go to groups,

there has been nothing like that recently. He gets a medication shot twice a month, although he said he does not know exactly what it is. He said he is supposed to see a counselor every two or three weeks but "you never know," and even when he does see his counselor, she just asks, "'how are you doing?' and that's it." Even though Mr. C.D.B. is scheduled to complete his sentence in a few months and knows he should be in a re-entry group, he is not.

33. I interviewed another Bullock prisoner housed in the open RTU dorms, Mr. F.W.B., who told me he first started having mental health problems when he came to jail, before coming to prison. He was put on Haldol when he got to prison, and was diagnosed as suffering from with paranoid schizophrenia. He told me that he had been in Suicide Watch cells several times in the past, primarily when he refuses to take his medications. The Haldol shots are the only therapy he has had: "I've been getting no other real treatment." He said staff tells him, "you don't have to see a counselor every time you have a problem—take care of yourself." Mr. F.W.B. also told me that "when my counselor was here, she wouldn't do real counseling—just asked me if I was OK. I tried to get into groups but they didn't put me in any" except for a "nursing" group that met only once and a "re-entry" group that met three times (but when the counselor who was running it left, no one took her place). He said a number of the correctional officers at Bullock taunted the prisoners: "Officers tell us bad things about ourselves, provoke us, [and] aren't very nice at times. I rarely ask to see a counselor but apparently it's too much."

34. While at Bullock, I also had confidential interviews with a number of prisoners from the facility's mental health Segregation Unit and the Stabilization Unit (housing units 8 and 9, respectively). Stabilization Unit inmate Mr. C.B. told me that his mental

health problems began when he came into the prison system in 2005. He suffered anxiety attacks at Kilby, spent some prior time at Bullock and remained on the mental health caseload as he traveled to several different ADOC facilities. He was at Bibb immediately before being sent to Bullock just a short time before we met. Apparently he was in an observation cell at Bibb, was "beating on the walls," and was sent to Bullock for more intense treatment. He said he suffers from paranoid schizophrenia, takes Haldol shots, and was receiving Social Security Disability at some point because of his mental problems.

35. I next interviewed Mr. N.R.B., a prisoner from the mental health Segregation Unit. He told me he was housed in the Segregation Unit because he had been "jumped on" by correctional officers. He claimed that the Warden told him at his classification hearing that she hoped he would "die back there" [in Segregation] because he was violent. He said he did not often go to the yard because being cuffed behind his back prevented him from doing much real exercise and also because he was afraid of being attacked by staff while in that vulnerable position. The yard is really the only out-of-cell time you can have back there, he said, so that means he stays in his segregation cell virtually around-the-clock, leaving only for five minute showers a few times a week. He said that, except for showers, "this [our interview] is the third time out of my cell since November." Although he reported that "lots of guys break down in [Segregation]," and they "take them away," there is very little meaningful mental health monitoring in the unit. He noted that "mental health comes through every week or two, says, 'you alright?' and keeps walking."

36. I also interviewed Mr. M.D.J., also housed in the mental health Segregation Unit at Bullock. He said he had long-standing psychiatric problems that pre-dated his time in

adult prison: "I've been seeing psychs since I was 10 years old, [and] getting meds in group homes." The medications he could remember taking included Abilify, Wellbutrin, Seroquel, and Celexa. He said that his mother encouraged him to seek mental health treatment in prison and he did, even though he believes that his status as someone on the mental health caseload prevents him from being eligible for work release. Currently, he said, he was prescribed and was taking Zoloft. Mr. M.D.J. emphasized that "mental health doesn't do anything in here. It's not worth doing it, even when you tell them about a problem, they ignore it. You only get meds, no real counseling. My counselor doesn't even know me." He told me that he had informed staff that he was suicidal, but they ignored him. Despite his statement that he was suicidal, he said his counselor never came to see him. He then put in a direct request to be taken to a Suicide Watch cell, but said the nurse told him "there was no room." He said, even when you are on Watch and someone comes to see you, "they spend 30 seconds with you." He described one incident in which he was put on Watch, but even after that his counselor never pulled him out for counseling. Instead, he said, after his time in Watch was over, they just put him back in the cell he had been in, without providing any follow-up treatment. He said another time, when he told the mental health staff he was suicidal, "they gave me three shots . . . all I did was sleep."

## BIBB CORRECTIONAL FACILITY

### Brief Interviews

37. During my tour of Bibb, I first spoke briefly with two inmates who were being housed in the Suicide Watch cells. One of the inmates in a Watch cell, Mr. B.E.C., told me that he was from the "Behavior Modification Unit" (B Dorm) and that the officers there "are trying to kill us." As I was speaking to him, one of the lawyers in our group noticed that the man in the adjoining cell, Mr. T.B., had placed a blanket over the window to the Watch Cell. Apparently he had a string or ligature of some sort that he had placed around his neck and was preparing to use it. A contingent of correctional officers was summoned and a sergeant resolved the situation with Mr. T.B. peaceably and I was eventually able to very briefly interview Mr. T.B. as well.

38. Later in the day, I learned from reading Mr. T.B.'s prison file that he had been placed on Suicide Watch several times in the previous year (in August and again in September, 2015). More recently, he learned that his sister had been shot and killed in January, 2016, began manifesting psychological problems at the beginning of March, 2016, and had become explicitly suicidal a few days before I saw him. Yet he continued to be housed in the Behavior Modification Unit, and was told that he would be sent back to that dorm from his Watch cell, despite his plea not to be returned there. The Behavior Modification Unit—the site of a riot or disturbance that modified our tour schedule (see my Report, ¶ 73)—is described by Bibb inmates as counter-therapeutic and rife with conflict and violence.

39. Once the immediate crisis with Mr. T.B. was resolved, I continued briefly interviewing prisoners who were waiting in the Infirmary. One of them, Mr. S.C.I., told me he had been beaten by correctional officers in the Behavioral Modification Unit, that

his injuries had required surgery, including inserting a metal plate into his face. He said that altercations take place in this unit "every day," and that there had been a riot there the week before. Another man, Mr. I.B.B., told me that he had his leg broken in the Behavior Modification Unit, in a fight with another inmate that occurred after Mr. I.B.B. had asked to be moved from the unit. After his broken leg was set, he said, he was moved right back into the Behavior Modification Unit, the unit from which he had asked to be transferred, and where the assault had occurred.

40. A short time later in my tour of Bibb, I saw the first of two small Bibb Segregation Units. They are unlike any I have ever seen. They are located in a remote location, around a long hallway, out of view of other inmates, and most importantly, out of view of any staff. The area outside the cells was dirty and smelled as though a fire had been set inside; some of the cell doors and floor had charring on them. The cells themselves are dark, filthy, and deteriorated. One prisoner, Mr. D.L.I., told me he had been in Segregation for a few days. He came to prison as a teenager, and had been on the mental health caseload until recently. Nonetheless, he was housed in this harsh and dangerous isolation unit.

41. In a different Bibb Segregation Unit, I met Mr. L.J., who told me that he had been kept back there since November, 2015, about four months. He said no one would tell him when he was getting out, that he had no phone calls or contact with anyone while back there. Mr. L.J.'s cellmate, Mr. X.M.I., told me he had been in that same cell for about three months. Both men said they had been denied cleaning material and that "we have to use our hands or dirty pieces of rag" (which they showed me) to clean their cell.

41. Another prisoner in the Segregation Unit, Mr. H.P.V., appeared to be especially distressed. He told me that he had been in this Segregation Unit for five months, and

that he did not know when or whether he was getting out. I later learned from reading Mr. H.P.V.'s prison file that he had been identified several years earlier as suicidal (as early as January, 2012), expressed thoughts of self-harm at Bibb in June, 2015, and was placed on Suicide Watch as recently as August, 2015, and had been housed in the Bullock Stabilization Unit. His "treatment plan" included recommendations that he receive "monthly counseling sessions," yet there was no record that any such counseling had taken place. Most troublesome, his file included recommendations that Mr. H.P.V. needed help gaining "increased . . . connectedness and socialization" through "increas[ing] group activities" and "work performance." Yet he was confined in one of the most isolating (and, for someone with a high risk of suicide, most dangerous) places imaginable.

42. During a tour of one of the large dormitories, one of the men I randomly selected to talk to separately,[2] Mr. I.L., told me he had been in prison half his life for a crime committed when he was 16 years old. He said he has talked to the mental health staff about his anxiety problems. He described the housing unit this way: "It is awful here—filthy. They are nasty—treat us bad. They degrade us and humiliate us all the time." I spoke separately to another prisoner from the dormitory, Mr. K.A.K., who said he had come from the HIV unit and that, although his sentence was completed, "they are keeping me here." He described living in the open dormitory this way: "It's hell in here. The officers and prisoners harass you." He said his medical status posed special problems for him in the dorm. It had led to him having what he described as "several nervous breakdowns," for which he said he had received psychotropic medications. He

[2] The ground rules for brief interviews in dormitory housing units required me to select individual prisoners in the unit before having talked to them, and interviewing them at a separate location within or just outside the unit.

was very thin and very nervous, and seemed particularly worried about how he would be treated after he spoke with me.

**Confidential Interviews**

43. I returned to the Infirmary to conduct a series of confidential interviews with some Bibb prisoners who had been identified in the tours, as well as some who I had preselected. The first, Mr. I.B.B., was someone I had seen earlier, in the Infirmary holding pen. He was still waiting there. He told me that he had longstanding mental health problems that predated his time in prison. He said he had been in prison for 20 years straight, and was diagnosed with PTSD and schizophrenia. He was now taking Zoloft and some other medications whose names he could not remember. He said that he had multiple prior suicide attempts and showed me a huge scar on his arm as evidence. Mr. I.B.B. described a recent incident in which he had become suicidal but was told by mental health that they did not believe him. He also told me that he had been extorted at the prison and that he feared for his life. When he informed prison officials at Bibb about his fears, they told him they had nowhere else to put him, so he was moved to the Behavior Modification Unit, even though that dorm is supposedly intended for problematic inmates whose behavior needs "modifying," and he had no write ups. Although the name of the unit seems to imply that it is somewhat therapeutic in nature, the inmates I interviewed said that it was anything but. In fact, the unit is apparently so conflict-ridden that, as I learned from Mr. I.B.B., prisoners refer to it as the "hot bay."

44. When I asked Mr. I.B.B. about mental health he replied: "Mental health? What mental health?" He listed a whole series of psychotropic medications he had been given in the past in ADOC but then said: "There is no treatment, no treatment period." Mr.

I.B.B. recalled a time in the early 2000s (perhaps in the aftermath of the Bradley settlement) when there actually were some classes offered at some ADOC facilities—he told me, "I took all of them"—but he also said "they gave you certificates for just sitting there." Since then, however, he told me that mental health consists of "about once a month you get called out for 5 or 10 minutes where they just ask you 'how you doing?'" He also told me he was kept in the Infirmary for about a month after a suicide attempt but was seen by mental health staff only once during that entire time. The huge scar on his arm was from his suicide attempt, done with a razor that he said he found in his housing unit. [See photo appendix, Ex. 5, Bibb.] He also said that inmates can purchase the razors at the inmate store, regardless of whether they are on the mental health caseload or have made prior suicide attempts. He said that after his suicide attempt, a correctional officer told him where he should have cut his vein if he wanted a better chance of succeeding in killing himself.

45. I also conducted confidential interviews with two prisoners whom I requested be brought from the Segregation Units that I toured earlier in the day. Mr. D.L.I. told me that he had been in the Behavior Modification Unit before being placed in Segregation. He said that the Behavior Modification Unit requires inmates to begin with nothing—they "take away every privilege you have, [even] before you have been found guilty." He told me that "every day" there is a conflict of some kind in that unit. Mr. D.L.I. said that he had been on the mental health caseload, diagnosed with depression and PTSD, and taking psychotropic medications. He told me that, other than his medication review every 90 days, he had no regular contact with mental health staff. He said that the Segregation Unit he is in now "is awful, horrible. They don't ever come back and check on us—you are just back there." He said that there was "nothing to do back there—we

just sit there," and that he was "on the verge of going crazy back there." Yet, since he had been in Segregation, "nobody from mental health came to check on me."

46. Mr. L.J. seemed very depressed when I spoke with him. His description of the conditions in Segregation was consistent with what I had seen and what other inmates told me. However, Mr. L.J.'s route into Segregation was especially problematic. Mr. L.J. said he had filed a PREA charge against an officer at Bibb, which resulted in him being put first in the Behavior Modification Unit (the "hot bay") and then into Segregation. He said that ADOC staff did nothing at the prison to protect him after he made the PREA allegation and that the officer against whom he filed the charge apparently remains employed there and in contact with Mr. L.J. He told me that he has a long mental health history that dates back to when he was 11 years old, and that he has been on extensive psychotropic medications, including Seroquel. Despite this significant mental health history, Mr. L.J. described his contact with mental health as sporadic, consisting mostly of those times when he asks to see someone, and the 90-day consultations that take place concerning his medications (which now include Remeron and Wellbutrin). Mr. L.J. said he was ordered by the court to participate in programming in order to be released from prison, but that there is no programming available at Bibb for him to enroll in. He is convinced that, because of his PREA charge, "they are trying to get me killed here." He said that the extent of mental health monitoring in Segregation, even for someone like Mr. L.J., who has a long psychiatric history, is that once a week a mental health counselor comes back to the unit and says, "tell me your name, let me know you are alive, and do you have any questions for mental health?" and then leaves.

47. I also interviewed Mr. C.S.Q., one of the named plaintiffs in the case. He said his psychiatric history dates back to before he was incarcerated and includes having been in

the inpatient psychiatric unit at Bryce Hospital. Mr. C.S.Q. told me he was diagnosed with paranoid schizophrenia, depression, and anxiety disorder, and that he takes Prolixin shots two times a month, in addition to Wellbutrin. He told me that he had been at the RTU at Bullock for some seven years and that during that entire time he got "no real therapy." He said that every month he had five minutes of mental health contact in which he was asked to sign his treatment plan, but that was all. Every once in a while, he said, there were some classes offered at Bullock: "I took what I could, I enjoyed them, but they didn't last long or have very many." He said that he is very unhappy and very afraid at Bibb. He told me he is exploited, extorted, and beaten up by other inmates and wants to go to another prison where, even if he cannot get therapy, he will at least feel safe.

48. Finally, I interviewed Mr. S.C.I., whom I had seen in the holding pen in the Infirmary earlier in the day. Mr. S.C.I. had facial wounds that he said he had suffered when a correctional officer beat him. [See photo in the photo Appendix, Ex. 5, Bibb.] He told me that, rather than being a therapeutic or treatment environment, the Behavior Modification Unit at Bibb is "for troublemakers, people with disciplinaries. The officers don't even come in the dorm bays, that's why all the trouble starts there, it's a free-for-all." He said that the unit was so out of control that, in addition to the incident that had recently shut it down, there was a full scale riot in the unit last summer in which the whole building nearly burned down.

**KILBY CORRECTIONAL FACILITY**

**Brief Interviews**

49. One of the units I toured and conducted interviews at in Kilby was one of its very stark Segregation Units, O Dorm. One of the prisoners, Mr. U.T.P., told me he had been held in this Segregation Unit for about a year, and now is "closed out," meaning that he will stay in Segregation. Another prisoner, Mr. I.I., said that he was immediately placed in Segregation because he was a juvenile and could not mix with adult prisoners—"I never went to the intake dorm—just here." Another minor, Mr. H.I., said basically the same thing.

50. I spoke to Mr. K.L.Z., who said that he was mentally ill but could not see his doctor back in the Segregation Unit. He told me he had been placed back in this unit for "mental observation" after being on Suicide Watch several times. Remarkably, several of the prisoners in the Segregation Unit–Mr. D.K., Mr. M.D.C., and Mr. E.D.–said that they had been in this very harsh unit for over a year. Mr. M.D.C. complained that the unit "is very bad—they brutalize you here—beat people up for just banging on the door."

51. I also toured the "Administrative Segregation" cells inside the Infirmary, where I spoke to Mr. Q.M.R., who was in a terrible-looking cell, in disarray with property strewn on the floor. He told me that he was in prison on a probation violation and that he had been placed in Segregation only because he has piercings on his body that cannot be removed. Apparently, prisoners are not allowed in the general population with piercings, so he was being housed in Segregation instead.

52. In a different Segregation Unit, Mr. N.K.A. told me that he had had "lots" of mental health contact on the streets, including being hospitalized for his psychiatric condition several times. In prison, he said, he receives a Prolixin shot. The only mental

health contact he has is that "once every couple of weeks" a mental health counselor comes to check on him.

53. I also spoke to a man on the mental health caseload, Mr. I.A.L., who was housed in one of the open dormitories, A Dorm. Mr. I.A.L. told me he was taking psychotropic medications for anxiety and PTSD and that he sees his counselor every couple of weeks but only if he asks for it—"nobody comes to see me or check on me."

**Confidential Interviews**

54. I conducted several individual confidential interviews with prisoners, including some from the large Segregation Unit ("Big Seg") at Kilby. One of the prisoners, Mr. D.J., said that the depressive atmosphere in Segregation was precipitating angry, homicidal, and suicidal thoughts. Mr. D.J. said he had an extensive psychiatric history before coming to prison. At age 12, he said, he was diagnosed with paranoid schizophrenia, and was placed in several mental hospitals. He also said that he has taken a wide variety of psychotropic medications, now and in the past. He described the Segregation Unit as "oppressive and crazy," and said he did not know what to do in order to get out.

55. Another Segregation inmate, Mr. K.L.Z., also told me that he had a long mental health history that pre-dated his time in prison and that he had received extensive psychiatric treatment in the freeworld. Indeed, he said that he was in several different mental hospitals by the age of 10, had been diagnosed as schizophrenic and bi-polar, and that he currently suffers from depression as well as serious anxiety problems. When he was on the street, he said, he took a wide variety of psychotropic medications, including Haldol and Seroquel. Mr. K.L.Z. complained at length about the lack of mental health care in ADOC. He said that as soon as he got to Kilby, mental health staff

recommended him for psychological observation and he was sent to O Dorm—the small but very harsh Segregation Unit that I saw at the outset of my tour. He told me that when he was there, "I told them I was hearing voices and seeing things. They said, 'we got something for that,' and gave me a Haldol shot." Then he went to the main Segregation Unit ("Big Seg"), where he stayed for about a month. He told me, "I've been about to hang myself back in Seg, they just ignore us." He told me about an incident when he wanted to see his counselor, but his request was ignored. He said he became desperate, so he threw water out of his cell to get staff's attention. Instead, he got written up, but his counselor still did not come to see him. Mr. K.L.Z. told me about another time that he stopped a mental health staff member who was seeing another prisoner in his unit and told him that he needed help. The staff member told him to "write down what I was feeling," so he did—"seeing people, hearing voices, it's too much pressure, too many voices"—but still no mental health staff member responded to him. He said, "nobody wants to come see you or care about you." He told me that conditions in the large Segregation Unit are terrible—"there are roaches and rats in Big Seg, they don't even bring stuff for you to clean your cells there."

56. I learned later, when I reviewed Mr. K.L.Z.'s prison file, that he did indeed have an extremely long, well-documented history of severe mental illness. His file dutifully recorded his long-standing, very serious mental health problems, including his schizophrenia "since age 10," his "daily" auditory and visual hallucinations and other symptoms, and his repeated instances of suicidality and multiple visits to Watch Cells. However, other than entries such as "a shot on yesterday to help with his symptoms" (2-19-16), there is no indication that he had received consistent, meaningful mental health treatment. To me, equally remarkable and troubling, despite this elaborately

documented and very serious mental health history, Mr. K.L.Z. was nonetheless subjected to the extreme deprivations and degradations of a very harsh Segregation Unit, one that even a strong and resilient prisoner would find difficult to tolerate, let alone someone with Mr. K.L.Z.'s profound vulnerabilities.

57. Finally, I interviewed Mr. I.I., a 17 year-old whom I saw earlier in the day in O Dorm, the small Segregation Unit I entered near the beginning of my tour. He told me that he had an extensive psychiatric history dating back to when he was 6 or 7 years old. He said "I'm treated like a caged animal . . . . The cells are awful, hard to keep clean. [My] toilet is about to come out of the wall." He said that although a mental health staff member comes through the unit, "she doesn't care" and she "talks smart to you." He also said he has seen prisoners in the O Dorm Segregation Unit roughed up: "They send the goon squad, shoot you with darts, take you away, and shoot you up." He said that this happens when someone refuses to take their shot. Mr. I.I. also said that the conditions and treatment there were getting to him: "You start to lose it in that room—it's happening to me; it happens to people, I've seen it."

## DONALDSON CORRECTIONAL FACILITY

### Brief Interviews

58. During my visit to Donaldson, I conducted brief cell-front interviews inside the facility's RTU, starting with S dorm, the "closed RTU." I spoke first with Mr. P.D.L., who had his window covered but then came to his door to tell me that "they want to kill me here," explaining that the staff was trying to force him to take Prolixin shots. Another inmate, Mr. E.E.S., mentioned the Bradley case and said that the Bradley consent agreement had "done good" but only when there was a monitor to oversee things. He went on to say that inmates in the S block, the "closed RTU" where he was housed, rarely go to the outside yard—only "once every three weeks"—and that many things have deteriorated at the prison, including the condition of the showers.

59. A prisoner on the top tier of the closed RTU, Mr. L.L.Z., told me that he had been in the unit for a couple of months and was being given forced medications—Haldol or Prolixin shots (he did not know which). He said he could not remember how long it had been since he went to the yard and that there were no groups run at Donaldson, just a counselor who comes by from time to time to talk at the door.

60. On a "closed RTU" block, one inmate, Mr. N.I., told me that prisoners in the unit "hardly" see their counselor and, when they do, "sometimes they talk to you, for maybe a minute. We don't get out for groups, [and] only go to yard every month or so." On the second tier, Mr. C.E.J. told me he was "stuck in lockup," because he does not take medications. He said that he was seen only once every 90 days, and that "you have to cut up to get attention." Mr. N.L. said that he had been back in this unit for about four months, during which time he had been to the gym twice but had not yet been given a chance to go to the outside yard. He said that a mental health staff member "comes back

here once or twice a week and stops by cells," and that "sometimes" they could spend as much as 10 minutes or so.

61. In the U Dorm, one of the "open" RTU units, there were in fact a few people out of their cells and walking around on the unit floor. One of them, Mr. Q.B., told me that he urgently wanted to see a doctor. He said that he had a bad reaction to the Prolixin shots he was being given. Mr. Q.B. told me he had been back in this RTU for two years, in one or another of the different units. But as we spoke, it was obvious that he was distracted by the pain he was in—he said he told the nurse but she would not listen, and then he began to moan in pain and walked off.

62. Mr. D.T.I. approached me in the open RTU and said "these people don't care," gesturing to the staff. He then told me a long and difficult to follow story about how badly the unit was run. He said that, other than the Haldol shot he gets, and a "current events" group that meets once every two weeks, he gets no treatment.

63. Mr. T.L.B., who also said he was taking Prolixin shots, could not remember how long he had been in the unit. He, too, said that there was a current events group that met every two weeks, and that "we go up front maybe once a month to talk to a counselor I think." Mr. C.A. also told me that other than the current events group every two weeks, "I get no treatment. The counselors are just like officers." He had complaints about his medications, which he said make him feel worse, but "I can't see a doctor, no matter what I say."

62. I went next to the Disciplinary Segregation Units at Donaldson, where Mr. N.C. told me, "this is hell. I've been in Seg since January. We rarely get out of our cells," except for showers every other day. Otherwise, he said, we "just sit in our cells." Mr. M.C. said that, other than showers, they have no regular program in the unit, and that

he has been offered yard time only once (in several months). Mr. M.C. also said that mental health staff does not come back there to check on the inmates.

63. On the other side of the prison, we toured additional Segregation Units, J and I. One inmate who I talked to cell-front, Mr. L.L.C., told me "it's bad back here." He, too, complained about hardly ever being allowed out of his cell to go to yard, and the infrequent mental health contacts. He said that mental health staff just started to come into the unit once a week, but although he had asked to be seen by mental health, "they never come to see me."

64. In the larger E Segregation Unit at Donaldson, I spoke with Mr. Q.D.L. cell-front. He told me that, although he was not on the mental health caseload, "mental health comes back once in a while and they just walk through quickly, spend a few seconds with people."

65. We entered an even larger Segregation Unit—W—which the captain informed me was a converted cellblock. Mr. K.J.A. said that the prisoners here get to go to the yard once a month and that mental health comes back to the unit no more than once a week or once every two weeks. Another prisoner, Mr. X.T.L., also said that mental health came back to the unit once or twice a month, and that the visits consist of the counselor asking "you okay?" and walking on. He told me that he has not been offered group activity of any kind, and the only regular program is a shower every other day. Mr. T.F.R. complained about officer mistreatment in Segregation, and told me that "officers jump on you back here."

66. In the Donaldson Infirmary I spoke to Mr. N.L.S. who told me he was confined to a "Z" cell, a version of Infirmary Segregation, where he said he had been kept since December 2014 because of a medical problem and the fact that he has a catheter. He

said he had not been outside for over a year and a half. Other than showers, he said, he just stays in his cell and sleeps.

**Confidential Interviews**

67. In addition to the brief cell-front interviews I have referenced in the above narrative, I also conducted a number of individual, confidential interviews with Donaldson inmates. Mr. K.J.A., a named plaintiff in this case whom I had seen earlier in the day, told me that he had been kept in Segregation for seven months. He said he believes that this is largely retaliation for his involvement in this lawsuit. He told me that, in November, he told a sergeant that officers were trying to have him killed; staff responded by putting him on Suicide Watch and leaving him there for 10 days. He said that on Watch, they "take all your clothes, gave me a suicide smock, no showers—doctors just come back to ask me if I was okay; [they] never tried to give me meds or anything [and] never any counseling." After ten days, they just put him back in Segregation, with no mental health follow-up or post-Watch counseling. Mr. K.J.A. was not sure whether he had a current mental health diagnosis, and if so, what it was, but he said that he previously had been sent to Taylor Hardin for psychiatric evaluation. At Taylor Hardin, he said, he was put on psychotropic medications, but just for a short time. However, Mr. K.J.A. was adamant that he has received no actual mental health "treatment" in prison.

68. Mr. T.P.Z. appeared very disturbed and angry when he was brought out for an interview. He said he had been involved in the original Bradley lawsuit and that he was punished because of it. He said he had not had a disciplinary write-up for over 10 years and that he is trying "to do my own time." He was very worried about being "overheard" during our interview (and pointed out that there were panels missing in the ceiling of

the room where the interview was being conducted and that perhaps this indicated that someone was listening in on us). He said that there is "no program" in T Block where he is housed at Donaldson. "The mental health woman comes every morning and asks if I want to hurt myself." He reiterated his concerns about retaliation and then told a story about getting forced Haldol and Prolixin shots at Holman, where he had been housed shortly before. Mr. T.P.Z. said a doctor at Bullock had diagnosed him as having schizoaffective disorder, and he told me: "I see images, they move and transform." Since he arrived at Donaldson, he said, he has been given a "large dose" of Prozac and then told me: "The have mental health 'hitmen' around here and, if you don't do what they want, they start to take you apart piece by piece." He said: "They're going to kill me here."

69. Mr. I.C., another named plaintiff in this case, told me that he came to Donaldson from St. Clair, about a year ago. He said he had a mental health history that dated back to when he was a juvenile, when he was given psychotropic medications. He was put on the mental health caseload first at Kilby, and then he was sent to Bullock. He said he got off the mental health caseload in 2010 because "it wasn't a real mental health program, just meds, no real counseling," even at Bullock. Rather, "they'd come into the unit, but not counseling sessions, and no groups" were being run at Bullock when he was there. After Bullock, he went to Segregation at St. Clair, which he described as "dangerous." At the time of our interview, he was in a general population dorm at Donaldson but said the mentally ill prisoners in his unit "aren't getting any real treatment—they are just taking meds." Although he is no longer on the mental health caseload himself, he said that he had engaged in many past incidents of self-harm, including being in Watch cell approximately six times. Even after an incident of self-harm in 2012, Mr. I.C. said, he

still was not put back on the mental health caseload. He said that this was because he did not want to take psychotropic medications, a prerequisite for being on the caseload. He said he has been diagnosed with bi-polar disorder, schizophrenia, and depression, but feels that the medications that he was on made him feel "tired and slow."

70. Named plaintiff Mr. K.B. said that he had been in isolation for a continuous eight-year period, on "institutional rotation" in which he was moved every three months to another Segregation Unit at a different prison. He said, "I started losing track of my family, I was moving so much." He spent the longest amount of time at Donaldson, which he characterized as "the worst." He began on the mental health caseload about ten years ago, and has been on a number of psychotropic medications, including Haldol (which he said made him drool). He said that during the entire time he was on the mental health caseload he was also in Segregation. He characterized this experience as "rough," in part because "they use the crisis cells as punishment. It's awful there. Feces on the crisis cell walls, the nurses don't check on you. I've been in crisis cells so many times I can't remember; many times I tried to kill myself." He went on to say that segregation time is mentally hard—"solitary confinement breaks you down mentally, you have anxiety and all this stuff but you don't realize it's happening to you." Yet, despite the stressful, painful nature of Segregation, especially for the mentally ill, they "don't have treatment for the mentally ill in Seg." He said that "you don't see the psychiatrist," not only at places like Holman but "even here"—at Donaldson, a facility that ostensibly has a mental health unit. He said the mental health counselor "comes around to your cell, runs by, 'you want to talk to mental health?' but half the time you don't even see them, they rush through." He said that they tell the prisoners, the "only thing we want to know is, are you suicidal?" Once a month they would "take you out to

your mental health counselor"—for what he said might be 10-15 minutes, at most—"[but] they change so often, you don't see the same person twice, so you don't form any real connection to them."

71. Mr. X.J.I. came to the interview with me from Suicide Watch, wearing a suicide smock, with his hands cuffed behind his back. He seemed to be heavily medicated. He also appeared very young—he told me that he was arrested at 16, came to prison at 18, and is now 23. Mr. X.J.I. said that he had recently tried to hang himself. He recounted a long mental health history, including multiple mental hospital stays, and a wide range of psychotropic medications that he had been prescribed (including a Prolixin shot that he said he gets every seven days). Mr. X.J.I. said that he has been in a treatment unit of some type the entire time he has been in ADOC custody, but complained that he wasn't really getting "treatment." He told me, "mental health comes and says, 'are you OK?' If you are asleep, or not at your door, they don't even ask you. Just go by." He said his counselor pulls him out of his cell "once every two months," but that officers hurry her up if she spends too long with inmates. He also goes to "treatment team" once a month but explained that it's "not really treatment, [they] just ask you questions, like they are criticizing you, like they want you out of their hair." Then he began to cry, leaning over and telling me, "this place is killing me. Please get me out of here. Please get me to Bryce."[3]

72. On the second day at Donaldson, I interviewed Mr. Q.B., who was the man from the previous day who was in such pain on his unit, complaining about the side effects of his medications. He seemed heavily medicated the second day, and was still in pain. He

[3] Bryce Hospital is a facility run by the Alabama Department of Mental Health that responsible for the provision of inpatient psychiatric services for adults throughout the state. See http://www.mh.alabama.gov/MI/Facilities.aspx?sm=b_c.

said that he had psychiatric contact on the street before coming to prison, had been hospitalized in Taylor Harden and Bryce, diagnosed with paranoid schizophrenia, and was now getting Prolixin shots. He explained that the infrequent groups that I heard about the day before are mandatory: "If you don't go to group, they threaten you, 'you are going back to T side,' which is just like Seg." But the groups "are a joke—we have current events group that doesn't help you with anything" and "the people who run group sometimes just take us to basketball." The groups occur perhaps two or three times a month, and last for about 45 minutes. He said that, on T side, "if you don't take your meds, they don't let you out of your cell." His monthly visits with mental health consist of "the doctor saying 'how are you doing? See you next month. Keep your nose clean and maybe you'll make parole.' That's as close as he comes to counseling." He said, "I don't see my counselor regularly now, but I used to see her for a minute—'how are you?' if you say, 'not so good,' she puts you right in a crisis cell. She'd come by your cell each morning but didn't really talk to you." When he was getting counseling, he said, it consisted of being taken once a week to the hallway, where you'd "sit on a chair with the officer standing alongside here, and talk to you—she'd spend five to seven minutes—she had 24 guys to see, everyone in T Block—she could do them in an hour or so." However, since he got to U Block, he said, no one has pulled him out, "there is no real activity there," and you go to the yard about "once every three weeks."

73. Mr. Q.B. said that no matter how bad things are at Donaldson, Holman is worse. "When you are in crisis cell [at Holman], they bring a riot team to force meds on you if you say no. They have five officers and an electric shield—open the door, rush in on you. [They] beat me for about five minutes, put the electric shield on my handcuffs to heat

them up, I was screaming and hollering—[they] kicked me, then the nurse gave me a shot [and they] put me back in my cell without any clothes."

74. Mr. P.D.L. talked at length about the conflicts he had with correctional officers, telling me that the "police at Holman beat me, beat me at Kilby too." He said he was on "Seg rotation" from 2011 to 2014. Mr. P.D.L. then spontaneously began telling a very elaborate story about a plan he believes is underway to implement "racial genocide" by substituting people's bodies and switching their identities without their knowledge. It was clearly something that concerned him very deeply and he described the plan in great detail. He was especially worried about being "punked out" himself and being substituted for someone else, and said it was a struggle to resist it. Despite obvious psychotic symptoms, Mr. P.D.L. said that he has been kept in a segregated housing unit of some sort for six years. He said that the only regular mental health care that he is being given, aside from psychotropic medication, is a daily visit from a counselor "for a minute, 'are you okay?'" and a meds review once a month. He told me, "I'm mostly in my cell around-the-clock."

75. Mr. E.E.S., whom I had seen cell-front the day before, said that things deteriorated at Donaldson after the Bradley agreement unraveled. He told me that he had been in one or another Segregation Unit continuously since around 2000, a period of nearly 16 straight years. At Donaldson, he said, he has been in a number of the RTU units and is now housed in S Block (where I saw him the day before). Mr. E.E.S. said that "mental health treatment" consists of a psychiatrist coming to the unit once a week, a mental health staff person coming through the unit three times a week, where she "spends a minute" and no more. There was "one group about five or six weeks ago" in S Block, it "lasted about a half hour," and they "never had it again."

76. Mr. I.A.Y., who came from one of the Donaldson open dorms, seemed very depressed when he spoke with me. He was also scared and anxious. He began by telling me that "it's pretty bad" at Donaldson. He told me that he came to prison at age 18, about 10 years ago. Even before coming to prison, he said, he had mental health contact and was taking psychotropic medications. He said that he started hearing voices when he was young, and had been to Taylor Harden, where he was evaluated for competency to stand trial. Apparently he was told there that he might be cognitively impaired. He described the recent circumstances that resulted in him being placed on Suicide Watch. He said: "I told them I was going to hurt myself, [they] didn't believe me, but I did." He then explained that he felt "real bad and I cut myself." He showed me a great many cuts on his arm which he indicated were from prior instances of self-harm. He told me that he had been to the RTU but that "it's nasty there." He also was at the RTU at Bullock, what he referred to as the "Blue Building." He said that "they don't come to you for help until an accident happens." Then he said: "The RTU here, why would someone want to go there? At this place, it's like Seg, not like Bullock's Blue Building where they have arts and crafts." He has stopped taking his medications and now sees mental health only once a month. Other than that, "I don't see anyone regularly." He does not have a job in the dorm where he is housed now: "I just sit in the dorm." He said he tells the staff he hears voices and that he's "going to 'do something,' because of the pressures, [but] they do nothing." Instead, he cycles back and forth between the Watch Cells and the dorms.

77. Mr. C.E.J. told me that he "scratched [his] wrist" in 2012, and was put in a Watch Cell, then transferred to the "Blue Building" at Bullock. There, he said, he saw a mental health person every day, and was pulled outside the unit to talk. He stayed there for two months, where they also put him on medications. However, when he was sent back to

Donaldson, his medications were stopped. He complained that he should be considered a mental health outpatient, but instead they have him housed in what he described as "lockup"—T Block in the RTU. He told me: "There's no mental health program for T—I've been in T for three months—we've had one group the whole time." He said that in the three or four months he has been there, they have gone to the gym three or four times and been outside even less. Mr. C.E.J. told me: "I say I need help, there isn't any. I'm an outpatient, but I can't take the isolation."

78. Another prisoner, Mr. K.C.Q. was very disturbed and agitated when he came to see me, rocking back and forth as we spoke. He also did not appear to be entirely tracking the questions that I was asking. He told me that he had been at Donaldson for about six years, and had been at Bullock before that. He said he has been in Segregation Units off and on for most of the time he has spent at Donaldson. He recalled that back during the time he was at Bullock, "we got to talk to people, outside our cell." But at Donaldson, he said, "I don't really have a counselor—an activity person comes to see me, but doesn't help me." He said he gets a Prolixin shot and also takes Celexa, but apparently nothing else in the way of treatment.

79. Mr. W.S.B. was very disturbed when I interviewed him and it was difficult for him to talk. He began by telling me he was "poisoned" at Holman, after which he was transferred to St. Clair, and then sent here to Donaldson in 2007, where mental health "started shooting me up with Haldol and Prolixin." He attributed his declining mental health in prison to the poisoning he suffered at Holman—he said he had been "doing good, but it "all went downhill" and "I started seeing demons after I was poisoned." Mr. W.S.B. said he comes up for parole next year but "they aren't doing anything to help me, just a Prolixin shot." He told me that he had been to a Watch Cell twice in the last eleven

months and said, "you get better nutrition in Watch Cells, where they give you a peanut butter sandwich."

80. Mr. C.D. told me that he had been at Donaldson for about a year and that "it's terrible here." Before coming here, he had been in the Kilby "Big Seg" unit for a year, the result of an automatic segregation placement because of his LWOP sentence. Big Seg, he said, was "so nasty—they have rats and everything there, really bad, but [it's] bad here too." He said that there are rats in the Segregation Units at Donaldson too. He also said that the mental health care at Donaldson is, if anything, even worse than at Kilby: the "psych here only cares about whether you're going to kill yourself, and she keeps it moving—doesn't care at all about us." He told me that a mental health person comes through the unit "maybe once a week; spends a minute or a second."

81. The final Donaldson prisoner with whom I conducted an individual interview was Mr. L.L.C., whom I had seen cell-front the day before. He told me that he had a very long psychiatric history, dating back to when he was 8 years old, and that it included taking psychotropic medications. However, he said that when he got to ADOC they refused to give him any medications. He said that this refusal continued over the last several years, despite his requests. The mental health contact he does get, he said, consists of a mental health staff person who "comes around every Tuesday—30 seconds to a minute, to a minute and 30 seconds, the officers lead them around—the officers set the pace, and the mental health person says 'I have to talk with the officer'—she'll just walk away, even if you are talking to her." He also told me that one time he told the counselor that he was having suicidal and homicidal dreams, but instead of a counseling session, "she sent me something to read."

82. I returned to Donaldson on June 2, 2016, to interview several additional prisoners. The first prisoner, Mr. C.A., told me that he was having a very hard time surviving. He said that the stress was getting to him, he was having chest pains and worried that he was going to have a heart attack. He said, "I can't take no more." Mr. C.A. is on the mental health caseload, in U Block, the least restrictive of the mental health units at Donaldson which, he said, means "we eat with population, go outside, but have very little else." Despite the fact that "they have very seriously disturbed people in here," he said, they get very little attention from the mental health staff. Mr. C.A., for example, said that he does not know the name of his mental health counselor and that she comes into the unit for no more than "10-15 minutes" in total. He said that the mental health counselors that he had in the past were also problematic—one would see you "only when you asked" and the other one "treated us like animals." He told me that, although they are supposed to have groups, they have not had one in two weeks and "we just get out of our cell with nothing to do." He described having been in Suicide Watch cells in the past and showed deep scars on his arms from prior suicide attempts. He said that he is currently taking Remeron and Artane, among other psychotropic medications (which are renewed via telepsychiatry). He said he had not had a decent night's sleep in 25 years.

83. A second Donaldson inmate, Mr. Q.S., is currently 64 years old and told me that he has spent most of his life in prison. He said he has a psychiatric history that pre-dates his time in prison. He said he is taking Remeron now, and has taken Thorazine, Prolixin, and Haldol in the past. Mr. Q.S. is on R Block, one of the less restrictive RTUs at Donaldson, but said he has been in and out of mental health treatment since he came to Donaldson in 1997, including having spent time on the more restrictive Donaldson RTU

Blocks (S and T). He said that mental health comes into his unit every day while the prisoners are locked in their cells and ask them how they are doing. The mental health staff often looks in and tells them to clean up their cells. If an inmate does not feel comfortable talking cell-front, he can ask to be taken out in the hall, but even then "an officer is right there—it's not confidential." Mr. Q.S. said that when the Bradley case first settled, they got actual one-on-one treatment, but that "over the years that slowly went away—we don't get that now. It was a lot better back then." He said that they have short group meetings, maybe two times a week, that last about 20 minutes or so, during which they talk about their medications. Otherwise, his "program" is to stay in his cell, watch TV when he is allowed out on the unit floor, go out to the yard twice a week, and eat in the dining hall with the general population. He said that he hears voices that he cannot control and that he gets "paranoid around people now." He also said that he has problems with depression, has cut himself, and been placed in Suicide Watch cells in the past. He said that the last time he was in a Watch cell, he only saw a doctor "on television," and that he was simply returned to his unit a few days later. He said that he did not get any special mental health attention or experience any change in his medication or treatment after that.

84. Mr. C.L.I. is one of the prisoners who was housed at Holman when I toured the Segregation Unit there in September and whom I wanted to interview. He said that he was never asked if he wanted to be interviewed (although I was told at the time that he had refused). In any event, he willingly talked to me, saying that he had been very upset by the suicide that had occurred in Holman back in September, 2015. In fact, he said, he had written a letter to SPLC lawyers about it. He said that the man who killed himself had been "kicking on his door, screaming, and begging to go on suicide watch. They just

ignored him" and locked him up. Not long after that, he killed himself. Mr. C.L.I. said that, in his own case, he had cut himself "to try to get some help for myself—they took me to the infirmary, the nurse didn't even bandage me, [and] after talking to mental health, she just had me go back to the unit." At Holman, he said, all they did for his mental health problems was to "give me meds," including Wellbutrin, Haldol, and Seroquel (at the same time). According to him, the mental health staff at Holman told mentally ill prisoners that "well, if you're going to kill yourself, we can't stop you." Mr. C.L.I. told me that he had come to prison while still a teenager (at age 16) and that he had experienced many psychological problems from the outset, including being in a Stabilization Unit a number of times and "in a crisis cell more times than I can count." He told me, "I did eight years in lockup. I was never the same since." He showed me the many scars he has on his arms from the many acts of self-harm and suicidality that he suffered in the past.

85. The next inmate I interviewed, Mr. X.B.X., was very agitated and in distress when he was brought out. He continued in this state as the interview proceeded. He told me that he had been in prison for the last 21 years and is now housed in T Block, one of the most restrictive of the RTUs at Donaldson—they are "locked up all the time" and only go outside only once or twice a week. He said that although a mental health person comes in the unit each day, "nobody really does therapy with you; just ask 'how are you doing?'" He said that he hears voices, "spirits," that talk to him. His mental health history predates his time in prison, including suicide attempts on the street (he showed me his scarred arms) and mental hospitalization for close to a year. He said that he has taken a wide variety of psychotropic medications, both in prison and before he was incarcerated, and has been in Suicide Watch cells a number of times in prison. He told

me that isolation (such as the unit he is in now) is especially problematic for him because the "voices get worse in isolation, the spirits make you do things and wake you up at night."

86. The next person I interviewed, Mr. E.P.C., appeared to be very medicated and disoriented, and he was often incoherent during the course of the interview. Apparently, he has been told he suffers from paranoid schizophrenia. When I asked him when he had come to prison, he said, "I traveled here on the day the world was dead, March, 1999." He told me that prisoners at Donaldson, where he has been since 2008, "are mostly locked in our cell." He said he takes Prolixin shots, which began when he started hearing voices at St. Clair. When I asked him how old he was, he said that he was born "in the year the world did a swap turnaround," and asked me if I knew what year that was. Mr. E.P.C. said that he had been on Suicide Watch many times in the past. He told me that the mental health staff person comes into the cellblock where he is housed "just about every day," and "she just says, 'how are you doing? Anything bothering you?' and if you say 'I'm okay,' she walks on." Mr. E.P.C. said he has no therapy groups and is never called out for one-on-one treatment. He said his "program" in RTU is "I just sleep all the time."

87. Mr. K.B. was brought for an interview from the Suicide Watch cell he has been in for the last several days. He told me that he was given heavy doses of Haldol and quite a few other medications, "but the Haldol made me shake a lot." Mr. K.B. said he was in Segregation Units at various places—moved every 90 days or so—from 2006 to 2015, where he got "basically no mental health treatment" except for seeing a counselor every 30 days. Now, he said, it is worse because "I don't see anyone but every 90 days" and "you don't see a doctor unless it's real serious." Even then, he said, "the mental health

counselors, when they call you out, [they] just ask you if you're okay, feel suicidal—if you're okay?—if you are, they just send you back." The last therapy group he could remember having was in 2012; as he put it, "they don't do therapy here." Mr. K.B. said the Suicide Watch cells, which he has been in, are "awful, terrible" and used as punishment—"no showers, terrible food, sleep on the floor, feces on the wall—they don't even clean the cell or disinfect it." Moreover, he said, "mental health doesn't really come back to check on you in the crisis cells. You are just back there" until and unless the doctor wants to see you.

## ST. CLAIR CORRECTIONAL FACILITY

### Confidential Interviews

88. On the day that I toured and interviewed at St. Clair, I was told that, apparently for "security reasons," the ground rules precluded any brief cell-front interviews in any of the housing units I entered. Some prisoners in the Segregation Units shouted out comments as I passed by their cells (for example, Mr. D.S. told me as I passed by the front of his cell that "there's bad stuff going on here—we don't get out, get showers, nothing"), but the information I learned from prisoners at St. Clair came almost exclusively from individual, confidential interviews conducted later in the day.

89. After completing my general tour of the facility, I began confidentially interviewing prisoners at St. Clair. Mr. I.R., housed in a general population unit at the prison, told me that he is now 56 years old and has been getting Prolixin shots since he was 13 years old. Mr. I.R. seemed heavily medicated and told me that he has a long mental health history in prison, which he entered in 1981, including time that he spent in Taylor Hardin from 1981-1983. He said he had multiple stays at Bullock. Mr. I.R. told me that he had arrived at St. Clair in 2002. He estimated that, in the general population dorm where he now lives, there are about 58 prisoners; he thought that no more than 2 of them had jobs, one was taking college courses, and that "the rest of us just hang out in the dorm, watch a little TV." He told me that "they don't have any real mental health program here," just pro forma visits from mental health twice a month and a visit with a psychologist ("Dr. Coogan") once a month,[4] for about an hour. He described being targeted by the KKK, who he said had threatened to kill him. He said that this had led to

[4] I found that prisoners often referred to Ms. Coogan, at St. Clair, and Ms. Harvey, at Holman, both of whom are certified registered nurse practitioners, as "doctor" or as "the psychologist."

him kidnapping a staff member—ostensibly to get the prison administration to take the threats seriously—and that resulted in him being placed for seven straight years in Segregation, four of which were spent at Holman and three at St. Clair. He said that when he was in the St. Clair Segregation Unit, mental health staff came to check on him once a week.

90. Another general population inmate, Mr. C.N.P., who also seemed heavily medicated, described having been on death row at Holman, before having his death sentence overturned and being given LWOP. He said that there was no mental treatment at Holman, and that once he left there he spent about four years in some form of Segregation, including a stint in Donaldson, where they "made me take Haldol shots." In addition to the Haldol, he said that when he first went to Donaldson years ago, he would be taken to a room where mental health would talk to him and that there would also be groups—"maybe one group a week." After that, however, he went back and forth between St. Clair and Donaldson, in 2006-2007, and then spent another four to five years in Segregation. During that latter period, "mental health would only take me out of [my] cell once a month or only come to [my] cell once a month." Now that he is in general population, he said his mental health program is more or less the same—"I see mental health counselor once a month, that's all," and once every six months he meets with a group (that is perhaps a treatment team).

91. A third St. Clair general population prisoner, Mr. Z.J.G., was incoherent at times during my interview. He told me that he had been in prison for a long time, and that prisoners were "being treated like a dog in here." He said he had been housed at Donaldson and at Bullock some years ago and, about five or six years ago, said he was in a Segregation Unit for approximately two years. As we talked, Mr. Z.J.G. became more

and more incoherent. He told me that he was innocent of his commitment offense, had been attacked in prison (and showed me the missing teeth that resulted), and that he had been in special education when he was a youngster.

92. The first confidential interview I conducted with Segregation inmates at St. Clair took place in the mental health office area just inside the Segregation Unit complex. I first interviewed Mr. Q.A.B., the man from the E Segregation Unit who had put his fist through the security glass window on his cell door earlier that day and who was, when I went through his unit, screaming almost uncontrollably about the mistreatment to which he had been subjected. He was calmer now and spoke very emotionally about the things that had happened to him at St. Clair. Mr. Q.A.B. said that he believed he had been targeted to be killed at St. Clair—that someone was trying to get into his cell to kill him and that the staff was not helping him ward off these attacks (and implied that they might actually be instigating or participating in it). He said that, in order to bring attention to his plight, he had set fire to his cell. This apparently resulted in him being forced to sleep outside last night, sprayed with a fire extinguisher, and not being permitted to shower or change his clothes. Before coming to St. Clair, he said, he was at Donaldson and Bibb, the latter of which he described as "out of control with mistreatment." However, St. Clair is, in his words, "hell," and he told me "what you saw today was everyday, it's hell there" [in Segregation]. He said: "We don't even shower every other day. We're supposed to go to yard every other day but often don't." Mental health staff, he said, "comes every blue moon," and only says, "how are you doing" and "then shoot by" your cell. He told me that "I don't recall a mental health person coming to my cell window and asking me how I am, not since I've been there." When I asked him about what had happened earlier in the morning, when he shoved his fist through

the security glass window on his cell door, he told me that he broke the window out because he was so upset and he could not breathe.

93. Another St. Clair prisoner from Segregation, Mr. G.E.P., said that he had come to prison at age 18, and has been at St. Clair for about six or seven months. He described the prison as "bad," told me that officers harass you, and said that he was maced just the day before. He also confirmed the story that I heard from others—that St. Clair prison officials keep prisoners outside overnight, including the men we saw who said they had been out there for three days. He went on to say that "it's very dangerous here, and the guards just let it happen—people getting stabbed up." He said that he was told that there were programs being organized for general population inmates at St. Clair, but in his experience they were so disorganized that they never happened. Mr. G.E.P. said he was on the mental health caseload but that even if you ask for help you are not likely to get it. He said that he had been taking Remeron since he was at Kilby and that it was helping him, but that Ms. Coogan had taken him off of it, against his wishes. He said that in the three to four months he had been at St. Clair, he had talked to a mental health counselor perhaps two times. He told me that he is supposedly scheduled for mental health visits every other week, and that he heard they consist of no more than being asked "how are you doing?" and spending no more than 5-10 minutes with the counselor, "but I haven't even gotten that."

94. The next prisoner I interviewed, Mr. T.A., said that he had been in Segregation for a long time—since 2013—and that "we have a terrible time here." Apparently he is being kept in Segregation for protection—"guys were looking for me to get me." He has been in a Suicide Watch cell that, he said, he was moved from after 19 or 20 days, even though he wanted to stay in it, because "they said they needed the cell." He said that

after he came off Watch, no one from mental health came to check on him. In fact, he said, he does not remember "when or if any mental health [staff] has come through to check on me."

95. I next interviewed Mr. E.L.C., the man whose disheveled cell I had entered earlier in the day. He was very depressed throughout the interview and told me that he has been living in that cell for almost a year. Mr. E.L.C. said he was "going through things" at Kilby, including hearing voices, which in part is what resulted in him being placed on Suicide Watch there for three weeks. He said that the medications that he has been given—Resperdol and Remeron—do not help, but "I don't get any other mental health treatment." He said that the mental health staff just walks through the Segregation Unit twice a month for what he described as "a few seconds." He told me that the inmates' "routine" in Segregation is extremely limited, consisting of three showers a week and going two times a week to yard (for about an hour each). Mr. E.L.C. said, "there is really nothing to do—just lie on my bunk and daydream and think. I hear the voices, I can't do anything but pray—I'm getting used to them."

96. Mr. D.C.G. told me that he had come into ADOC as a 17 year-old teenager and is now 38 years old. He has a significant mental health history, having been put on Thorazine when he first came into the system, at Kilby, years ago. He said he was also at the Bullock mental health unit in 2010. Mr. D.C.G. said, "I'm on Seg rotation, so they moved us around." He told me that, to his knowledge, they do not do mental health rounds in Segregation, but rather see prisoners on the mental health caseload in the mental health office once a month. However, "sometimes the officers don't want to bring us, and they say we refused." As infrequent as the "monthly" contacts are, he said that last year they were only seen every 90 days.

97. Nonetheless, Mr. D.C.G. said that he wants to get mental health treatment—"I keep on asking for mental health programs or treatment, [but] the mental health counselor doesn't follow up." He said he has been on Suicide Watch in the past, including once in 2009, after his mother passed away. However, he said that he got into a dispute with "Dr. Coogan" and that she took him off his medications. Mr. D.C.G. said that he has heard voices in the past and has also tried to kill himself several times, and was on Suicide Watch at Holman. He recalled having been on a variety of psychotropic medications in prison, including Thorazine, Prolixin, and Haldol, and said that there were times he shook so much from the medication that he could not write a letter and other times when he was so drugged he could not move his hands.

98. Mr. D.C.G. also described callous and cruel behavior on the part of some of the St. Clair custody staff. He recounted a story in which "last month, a prisoner cut himself to kill himself and the guard said, 'let him bleed.'" He went on to say, "this prison is really dangerous, the staff doesn't keep you safe. Officers will roll the doors and you can get killed. Inmates pay them to open the doors." Mr. D.C.G. also confirmed that prisoners were being kept outside overnight, something that resulted in feces and urine in the yard, which he said deterred prisoners from going out there for yard time. But, he said, "my main concern is the lack of mental health care, especially because I want to go home some day."

99. We returned to the Infirmary, where I earlier had identified two inmates in Watch Cells whom I wanted to interview confidentially. Mr. L.J.Q. told me that he was back in the Infirmary Watch unit because he was "under observation," and had been for some 30 days, during which time he had eaten only peanut butter sandwiches. He said he was supposed to be transferred to a Stabilization Unit (a place that he had been

before, as well as having had a number of placements in Watch Cells), but that it had not yet happened, so he is being kept in the Infirmary cell. The only "treatment" he said he gets is that Ms. Coogan "comes once a week for 5 minutes and leaves." He said a counselor also comes "once a week for a couple of minutes, gives me a workbook and a pencil." He told me: "I don't want to keep cutting on myself, it's bad but I don't know what to do or how to move forward." Apparently, one of his suicide attempts resulted in hospitalization and required 30 stitches to close the wound. He said "Ms. Coogan is the only person I've seen and I heard she's not even a psychiatrist."

100. Mr. X.M.B.—the man who was lying on the floor of the "Mental Health Office" earlier in the day, was now awake. I spoke to him through the door of the office where he was still being housed. He told me that he came into prison at age 17 and, even before that, he already had many mental health problems, including having been given psychotropic medications. He said "I wasn't getting real mental health care in Seg. Once a week, with a counselor, [for] just five minutes." This was true despite the fact that he had been on Watch, he said, perhaps 10 different times. The office room where he is being housed, as I noted in my Report, had no bunk or toilet, so Mr. X.M.B. was forced to sleep on a mattress on the floor. Prison staff had given him a plastic jug to urinate. He told me that he had been in this room, living this way, for "a couple of days."

101. I returned to St. Clair on June 3, 2016, to conduct several additional interviews with prisoners whom I had been unable to see on my prior visits. The first inmate, Mr. T.R.Z. was soft-spoken 29 year-old man whom I interviewed in the main visiting room area at the prison. He said he had come to prison a little less than 10 years ago. He was housed at Holman back in September, 2015, when I visited the Segregation Unit there and was on my list of intended interviewees. He told me that he remembered the tour

but, in fact, was never asked by staff whether he wanted to be interviewed. Mr. T.R.Z. confirmed what others had told me—that the chaotic, tumultuous scene I encountered that day at Holman "was pretty much everyday—a madhouse." He said he had gotten on the mental health caseload for depression, sometime in 2013. At Holman, he said, mental health care was "non-existent." He could recall having seen the "mental health lady" maybe twice during the time he was in Segregation, which he said consisted of the officer bringing him up to the front of the unit and standing by while he talked to mental health staff—"no privacy, lasted 2 minutes each time, talked about pretty much nothing." Even that, however, was more than he had gotten in population at Holman—he said that over about a 13-month period there he had no mental health contact at all. However, he has since decided to go off the mental health caseload, "because they never came to talk to me unless I asked anyway, so I didn't see the purpose."

102. Mr. T.R.Z. also confirmed what others had told me about the suicide that occurred in September, 2015 at Holman—that the man was "asking for help, they ignored him. The night he did it, [staff] walked right past his cell at pill call." He also said that Holman was plagued with violence—prisoners in the Segregation Unit had knives and he saw people stabbed perhaps a half dozen times in his three months in the unit. He saw such a stabbing the first time he went to the yard there and it frightened him so much he never went to the yard again. He told me that there were prisoners in the Holman Segregation Unit who had handcuff keys or could pick the locks on their cell doors so that could get out. He also said that there was a hole in the shower area wall that allowed people to climb out and then be on the open tier, un-cuffed. This meant that, if a prisoner was being escorted in the unit in handcuffs, he would be defenseless against such an attack. He told me that although the Segregation Unit at Holman was

very dangerous and the conditions degraded—for example, he said the light was out in his cell for about three weeks before anyone fixed it—he said that "the dorms [were] also awful—lots of upset and angry people, [only] one officer in the dorm—we are packed together, [there] were people getting stabbed." Even so, he thought there were more knives in Segregation than population. He told me that over 80 knives had been found in the Holman Segregation Unit last year, when the riot team went through and carefully searched the unit.

103. The second prisoner I interviewed at St. Clair, in June, 2016, Mr. E.L.Q., was seen in an office area back in the facility's Segregation Unit. He told me he was 38 years-old and had been in prison for about 16 years. Mr. E.L.Q. corroborated the stories I had heard about Segregation prisoners being left outside overnight—"they leave people outside overnight—handcuffed and shackled—they'll leave you out there for days if they want to, even in the rain." He told me that he went on the mental health caseload in 2014, when he started to get very bad headaches and began hearing and seeing things. He said he has been taking different psychotropic medications, including Zoloft and Geodon, but otherwise his mental health contact has consisted only of being seen once every two months. Mr. E.L.Q. told me, "the guards tell me that I can't see mental health because they don't have enough staff to escort us . . . so we can't go." He said, "we have no program, we have regular lockup and 'doghouse," [which] is lay down, sleep, eat," as compared to "regular lock up [which] has store and phone privileges." He said he had been in Segregation for four months and did not know when or how he would get out.

104. Mr. E.L.Q. told me that there were a number of men in Segregation at St. Clair who were "having a hard time . . . it's nasty and hard to deal with psychologically." He said that just yesterday a man in his unit had tried to commit suicide by hanging

himself, and that the guards carried him out of the unit by his arms and legs, not even on a stretcher—"he was a guy who they'd left outside for two days, he didn't want to go to the doghouse but they forced him, so he tried to commit suicide once they did." He said that the mental health staff simply does not monitor the prisoners in Segregation—the mental health counselor has come back in the unit twice in the four months that he has been confined there. He also said that the general population at St. Clair was dangerous—"there are so many folks on the yard with knives, you aren't safe, and you can't trust the guards to protect you, plus they mistreat you."

105. When Mr. K.J.I. was brought out to me he seemed disheveled and disoriented. He told me that his mental health history pre-dated his incarceration in 2005, and that he was diagnosed as suffering from paranoid schizophrenia. Since entering ADOC at Kilby, he has been given Prolixin shots. Mr. K.J.I. explained that he had been sent to Segregation as punishment for not taking a Prolixin shot. He said he does not like the Prolixin because it makes him feel dizzy, and that one day he told the staff he did not want to take it. He said the staff held him down, gave him the shot, and then put him in Segregation for refusing it. He said he has been there ever since (about two months). He told me "they don't come see me or interview me, just take me to the mental health office to give me a shot and send me back." He is clearly suffering in Segregation—"it's bad back here, really dangerous." He said there are "no mental health rounds in this lockup . . . there are guys screaming and starting fires—they had a fire in my block yesterday." But "this ain't no camp for a mental patient." He said, "I have nothing to do in my cell, they hardly take you to the yard—I last went two weeks ago—they say they are short officers." He said that all there is for him to do in the unit is to "lay down, or I look at the window, go out for 45 minutes every two weeks."

106. The last prisoner I interviewed at St. Clair, Mr. E.H., said that he has been in prison for a long time—30 years—and is now on involuntary medication status, taking Prolixin shots. He said his mental health problems started after he had come to St. Clair, and was put in "the doghouse" (the facility's harshest form of Segregation) in 1989. Since then, he has been to the RTU at Bullock twice, and spent most of his time in numerous Segregation Units in ADOC, including at Holman. He told me that he tried to commit suicide twice before in prison. Mr. E.H. said he does not like the Prolixin because it makes him sleep. He said "I do nothing" except to stay in his cell and go to the yard when it is offered. He also said that the "guards will give you a cigarette if you don't shower; they don't want to take you to shower." His mental health contact consists of visits every two weeks from a staff member who "brings paper, puzzles, comes to the cell and talks to us cell-front," but only spends "a few minutes with you." He also told me, "I told [the mental health counselor] once I was suicidal on a Friday and he said, 'I'll see you Monday.' He doesn't spend any real time with you—ten minutes at most." He said the counselor has him taken out of his cell, to the mental health office, for perhaps five minutes, once each month. He said the counselor told him that he could not do it more often "because there aren't any staff to take us." Even at Bullock, however, where he supposedly went for specialized mental health treatment, he said he was not getting much more contact than the minimal amount that occurs at St. Clair.