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February 10, 2019

Patricia A. Coyne-Fague, Acting Director
Rhode Island Department of Corrections
40 Howard Avenue
Cranston, RI 02920

Dear Director Coyne-Fague:

We write to express our concern about the conditions of isolation and solitary confinement imposed on prisoners in Rhode Island, especially those with severe and persistent mental illness (SPMI). Over the past year, Rhode Island Disability Law Center (RIDLC) has investigated those conditions and concluded that the severity and length of isolation imposed on prisoners with SPMI in Rhode Island raises serious constitutional, human rights, and human dignity questions.

We know that the Rhode Island Department of Corrections (RI DOC) has taken important steps toward reform of solitary confinement and isolation practices in the past few years. We applaud that leadership and the work of your staff in implementing those reforms. Now we would like to meet with you to discuss the possibility of implementing reforms to the conditions for all prisoners with mental illness in Rhode Island's isolation units as well as a real and sustained treatment program for individuals with SPMI in the Residential Treatment Unit (RTU). We propose a meeting during the week of February 18, 2019.

Conditions for Prisoners

As mentioned above, we have been investigating the conditions for prisoners with mental illness in isolation units in Rhode Island for some time. Our investigation found conditions of extreme isolation, including 23 hours of solitary confinement Monday through Friday and 48 consecutive hours every weekend. In some facilities there is not even access to outdoor exercise so that prisoners spend all day, every day in concrete boxes. All Rhode Island prisoners in isolation are forced to spend nearly their entire lives in a steel and concrete cell the size of a small parking spot. In these tiny cells, prisoners eat, sleep, use the toilet, and spend almost all of their waking hours. Their ability to interact with other human beings is extremely limited; this is exacerbated by the fact that communication often only occurs cell-side through small window openings in steel doors. This means that any limited interactions prisoners have with officers or medical staff are attenuated and not meaningful. The narrow windows in the cell door permit only a restricted view onto the cell block, and the cells have only a limited view of the outside world. All meals are eaten in the cell. Prisoners in isolation are permitted very little contact with the outside world. Those prisoners in disciplinary confinement are denied visits, and are only allowed one ten-minute phone call to

family members after 30 days in solitary confinement And they are denied all access to congregate religious services, rehabilitative, vocational, educational, or other programs.

In Rhode Island, prisoners, including those with SPMI, can spend weeks, months and even years in these conditions. Prisoners are subject to the devastating effects of solitary confinement even though it is well known to cause serious and permanent harm.[1] Research consistently shows that solitary confinement is painful, stressful, and extremely psychologically harmful.[2] Such outcomes are well known to mental health practitioners in corrections. As a prison staff psychiatrist told Human Rights Watch, "[i]t's a standard psychiatric concept, if you put people in isolation, they will go insane. . . Most people in isolation will fall apart."[3] In Rhode Island, many men and women will be broken beyond repair due to the time they spend in solitary confinement – their minds irreparably damaged before the State returns the vast majority to the community. All will suffer needlessly, unsupported by any valid penological justification.

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[1] *See generally* Elizabeth Bennion, *Banning the Bing: Why Extreme Solitary Confinement is Cruel and Far Too Usual Punishment* 18-23, 90 INDIANA L.J. 741 *available at* http://ilj.law.indiana.edu/articles/14-Bennion.pdf (summarizing the research on psychiatric harms of solitary confinement).

[2] For research on the cognitive and mental-health impairments that solitary confinement causes, see Craig Haney, *The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful*, 12 Prison Serv. J., at n. 1 (2009); B. Arrigo & J. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and What Should Change*, 52 INT'L J. OFFENDER THERAPY & COMPARATIVE CRIMINOLOGY 622-40 (2008) *available at* ; https://www.safealternativestosegregation.org/wp-content/uploads/2018/12/The-Psychological-Effects-of-Solitary-Confinement-on-Prisoners-in-Supermax-Units.pdf; Kristin Cloyes et al., *Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample*, 33 CRIMINAL JUSTICE & BEHAVIOR 760-781 (2006) available at http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.861.2701&rep=rep1&type=pdf Peter Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUSTICE 441-528 (2006), *available at* https://www.jstor.org/stable/10.1086/500626?seq=6#metadata_info_tab_contents; Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime & Delinquency 124, 127 (2003) *available at* https://www.researchgate.net/publication/249718605_Mental_Health_Issues_in_Long-Term_Solitary_and_Supermax_Confinement (finding high psychological trauma rates including more than 80% of prisoners suffering from anxiety, headaches, troubled sleep, or lethargy; 25% reporting suicidal ideation; and over 50% reporting symptoms including heart palpitations, obsessive ruminations, confusion, irrational anger, withdrawal, violent fantasies, chronic depression, hallucinations, perceptual distortions, emotional flatness, and depression); Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 Am. J. Psychiatry 1450, 1450-54 (1983) *available at* https://pdfs.semanticscholar.org/e72b/5725f6cf0c16323a391c97be5e0da033dc0e.pdf; (finding "strikingly consistent" symptoms, including massive anxiety, perceptual disturbances such as hallucinations, cognitive difficulties, memory lapses, and thought disturbances such as paranoia, aggressive fantasies and impulse-control problems among Massachusetts prisoners in isolation).

[3] HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 149 n. 513 (2003), *available at*. https://www.hrw.org/reports/2003/usa1003/usa1003.pdf.

Building a Better System

Across the country, numerous states and the federal government have initiated policies to investigate, monitor, and reduce the use of solitary confinement, building on a growing recognition that isolation is dangerous, counterproductive, and costly. Rhode Island has been part of this trend to some extent. We are aware of the efforts made by the special legislative commission to study and assess the use of solitary confinement in Rhode Island's Adult Correctional Institutions. The Commission was empowered "to make a comprehensive study and assess the use of solitary confinement in the Rhode Island ACI, including, but not limited to . . . [r]ate and length of solitary confinement sentences . . . [and] [a]lternatives to and best practices for reducing the use of solitary confinement . . ."[4]

Commission members made a variety of recommendations meant to be implemented administratively rather than legislatively.[5] These included limiting the offenses for which an individual could be placed in disciplinary confinement, decreasing the maximum sentences of solitary confinement, increasing programming availability, and excluding vulnerable populations from solitary confinement.[6] The Department of Corrections adopted some of these recommendations, but would not commit to placing specific time limits on solitary confinement sentences, allowing personal visits to individuals in solitary confinement, or providing for how long it would take to give individuals in solitary written plans to assist in their release.[7]

Despite the improvements that have been made, critical underlying problems remain, especially for individuals with SPMI, who are still not excluded from solitary confinement in policy or practice. Although R.I. DOC internal policy now says that individuals with SPMI who are or would otherwise be placed in restrictive housing will be "identified by Behavioral Health Services staff for placement" in a residential treatment unit, R.I. DOC § 12.27 at 7 (2018), the new policy merely states that:

> Inmates with SPMI, who are currently in restrictive housing, are identified by Behavioral Health Services staff for placement in the RTU. If identified as such inmates may not opt out of program participation.[8]

In practice, only a small percentage of prisoners identified as SPMI are being diverted from the solitary confinement units to the Residential Treatment Unit (RTU). This is demonstrated both through record review conducted by RIDLC and monthly rosters of the prisoners with SPMI in

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[4] H.R. Res. 8206 Sub A (R.I. 2016).
[5] *See* H.R. SPEC. LEGIS. COMM'N TO STUDY AND ASSESS THE USE OF SOLITARY CONFINEMENT AT THE R.I. ACI REPORT 2 (2017) [hereinafter H.R. REPORT].
[6] *See* H.R. REPORT at 12-13.
[7] *See id.* at 17.
[8] 12.27 DOC, CONDITIONS OF CONFINEMENT, §4(B)(1)(g) (Feb. 26, 2018).

solitary confinement which consistently demonstrate that the vast majority of people with SPMI remain in solitary.

The RTU developed by RI DOC has also proven to be totally insufficient. Over 2018, RIDOC gradually opened the RTU in the maximum security unit with 12 beds. RIDLC has been monitoring placements in this unit and noted that no more than 8 men have ever been placed in the unit at a time. RI DOC also appears to be using some of these beds as treatment rather than diversionary beds for individuals in the isolation units with SPMI. The goal of this unit is the 10/10 model, which requires ten hours of out-of-cell treatment and ten hours of unstructured time out-of-cell per week, but notably, the 10/10 model is not actually required by policy; it is merely aspirational.[9] As a result of the RTU's limited capacity (and lack of other therapeutic alternatives), vulnerable individuals with SPMI are still subjected to extremely harmful, non-therapeutic conditions in solitary confinement.

Further, although the Commission has stated that pregnant prisoners will be excluded from restrictive housing altogether,[10] we could not find any RI DOC policies memorializing that agreement. Moreover, there is no RTU for women. We are also concerned that many women appear to be disproportionately placed in isolation for low-level disciplinary issues.

We are encouraged by RI DOC's initial steps towards reform but it is simply not enough, especially for the many individuals with SPMI who remain trapped in isolation conditions. Decades of research establishes that solitary confinement is psychologically difficult for even relatively healthy individuals, but it is shattering for those with mental illness.[11] As a result, rates of suicide and self-harm are shockingly high for prisoners held in solitary confinement.[12] Indeed, the extreme social isolation and environmental deprivation of solitary confinement may fundamentally alter the human brain. Neuroscientists and medical experts are increasingly

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[9] RESIDENTIAL TREATMENT UNIT (RTU) INMATE ORIENTATION MANUAL 2018 at 3 (describing ten hours of structured programming and 10 hours of unstructured time per week as a "general rule").

[10] *See* H.R. REPORT at 16.

[11] *See, e.g.*, Stuart Grassian, "Psychopathological Effects of Solitary Confinement", Am. J. of Psychiatry, Vol.140, No. 11, 1450 (1983) https://pdfs.semanticscholar.org/e72b/5725f6cf0c16323a391c97be5e0da033dc0e.pdf; ; Richard Korn, "The Effects of Confinement in the High Security Unit at Lexington", Soc. Just., Vol.15, No.1(31), 8 (1988) available at https://www.jstor.org/stable/29766384?seq=1#page_scan_tab_contents ; S.L. Brodsky and F.R. Scogin, "Inmates in protective custody: First data on emotional effects", Forensic Rep., Vol. (4), 267 (1988); Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement", Crime & Delinquency, Vol. 49, No. 1, 124 (2003) available at https://www.researchgate.net/publication/249718605_Mental_Health_Issues_in_Long-Term_Solitary_and_Supermax_Confinement ; Holly A. Miller and Glenn R. Young, "Prison segregation: administrative detention remedy or mental health problem?", Criminal Behaviour and Mental Health, Vol. 7, No. 1, 85 (1997); Hans Toch, *Mosaic of Despair: Human Breakdowns in Prison*, (American Psychological Association, 1992).

[12] Homer Venters et al., "Solitary Confinement and Risk of Self-Harm Among Jail Inmates," Am. J. Public Health, Vol. 104, No. 3, 442-47 (2014), retrieved from http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742.

raising alarms over the long term impacts of solitary confinement on human health and functioning.[13] It is time for Rhode Island to stop inflicting this level of pain and damage on its prisoners.

Evolving Legal Context

Given the decades of research and experience around solitary confinement and our evolving knowledge about the human brain, it is unsurprising that there is strong new momentum in the United States to reform solitary confinement. This momentum is the product of a broader cultural rethinking of the practice, its impacts, and outcomes. Civil rights litigation is playing an important role in this cultural ferment by simultaneously driving systems reform and exposing the harms solitary confinement wreaks on incarcerated people. Beyond Rhode Island, recent court decisions and settlements in states like Massachusetts,[14] California,[15] and Arizona[16] are leading to the further development of alternative approaches to the management of seriously mentally ill and cognitively disabled individuals in corrections. Ground-breaking litigation in New York led to the exclusion of youth under 18 and pregnant women from isolation units in the state prisons.[17] In California, the state's use of long-term solitary on thousands of prisoners based solely upon gang affiliation is now being dismantled due to a settlement that has already led to the release of a significant portion of the state's segregation population back to general population.[18] Litigation in Pennsylvania, including *Johnson v. Wetzel*[19] and *Shoatz v. Wetzel,*[20] has demonstrated the courts' increasing reluctance to allow the use of long-term solitary confinement on anyone. Very similar litigation is now pending in the U.S. District Court in Rhode Island.

This growing momentum for change is best encapsulated by the outspoken criticism of the practice repeatedly voiced by former Supreme Court Justice Anthony Kennedy. In *Davis v. Ayala*, Justice Kennedy took note of the fact that Hector Ayala was in solitary confinement, and acknowledged that while the physical and psychological toll of solitary confinement is well-documented, insufficient public attention has been given to the issue. But Justice Kennedy also

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[13] Carol Schaeffer, "'Isolation Devastates the Brain': The Neuroscience of Solitary Confinement," Solitary Watch, May 11, 2016, available at http://solitarywatch.com/2016/05/11/isolation-devastates-the-brain-the-neuroscience-of-solitary-confinement/ .

[14] Mem. Op. & Order, *Disability Law Center, Inc. v. Massachusetts Department of Correction, et al.,* 960 F.Supp.2d 271 (D. Mass. Apr. 12, 2012).

[15] Order, *Coleman v. Brown*, 28 F. Supp. 3d 1068 (E.D. Cal. Apr. 10, 2014).

[16] Order, *Parsons v. Ryan*, Docket No. CV-12-00601-PHX-DJH, Doc 1458 (D. Ariz. Feb 25, 2015). https://www.clearinghouse.net/chDocs/public/PC-AZ-0018-0038.pdf .

[17] Stipulation for a Stay with Conditions, *Peoples v. Fischer*, No. 211-CV-02694-SAS (S.D.N.Y. Feb. 19, 2014). https://www.clearinghouse.net/chDocs/public/PC-NY-0062-0010.pdf .

[18] Settlement Agreement, *Ashker v. Brown*, Case No. 4:09-cv-05796-CW (N.D. Cal. Aug. 31, 2015.), *available at* http://ccrjustice.org/sites/default/files/attach/2015/09/2015-09-01-ashker-Settlement_Agreement.pdf .

[19] Mem. Op., *Johnson v. Wetzel*, et al. 209 F. Supp. 3d 766 (M.D. Pa. Sept. 20, 2016).

[20] Mem. Op. & Order at 12, *Shoatz v. Wetzel, et al.*, No. 13-cv-0657 (W.D. Pa. Feb. 12, 2016), *available at* https://law.justia.com/cases/federal/district-courts/pennsylvania/pawdce/2:2013cv00657/209977/87/.

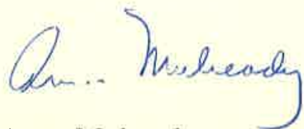
noted a "new and growing awareness" about the problems associated with solitary confinement and, most notably, appeared to invite a case to address these problems directly: "In a case that presented the issue, the judiciary may be required, within its proper jurisdiction and authority, to determine whether workable alternative systems for long-term confinement exist, and, if so, whether a correctional system should be required to adopt them."[21]

We believe that the RI DOC can find a "workable alternative system" to its use of solitary confinement, especially for those with SPMI without the need for court intervention. As discussed above there are a number of successful approaches used by other states that Rhode Island can consider. RIDLC staff look forward to discussing these options and other approaches with you. Please let us know if February 19, 2019 is an available date to meet or if there is another time that works with your schedule in the next month.

Sincerely,

Brian Adae
Staff Attorney

Steven Brown
Executive Director
ACLU of Rhode Island



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cc: Kathleen M. Kelly, Esq.,
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[21] *Davis v. Ayala*, 135 S.Ct. 2187, 2208 (2015) (Kennedy, J., concurring).