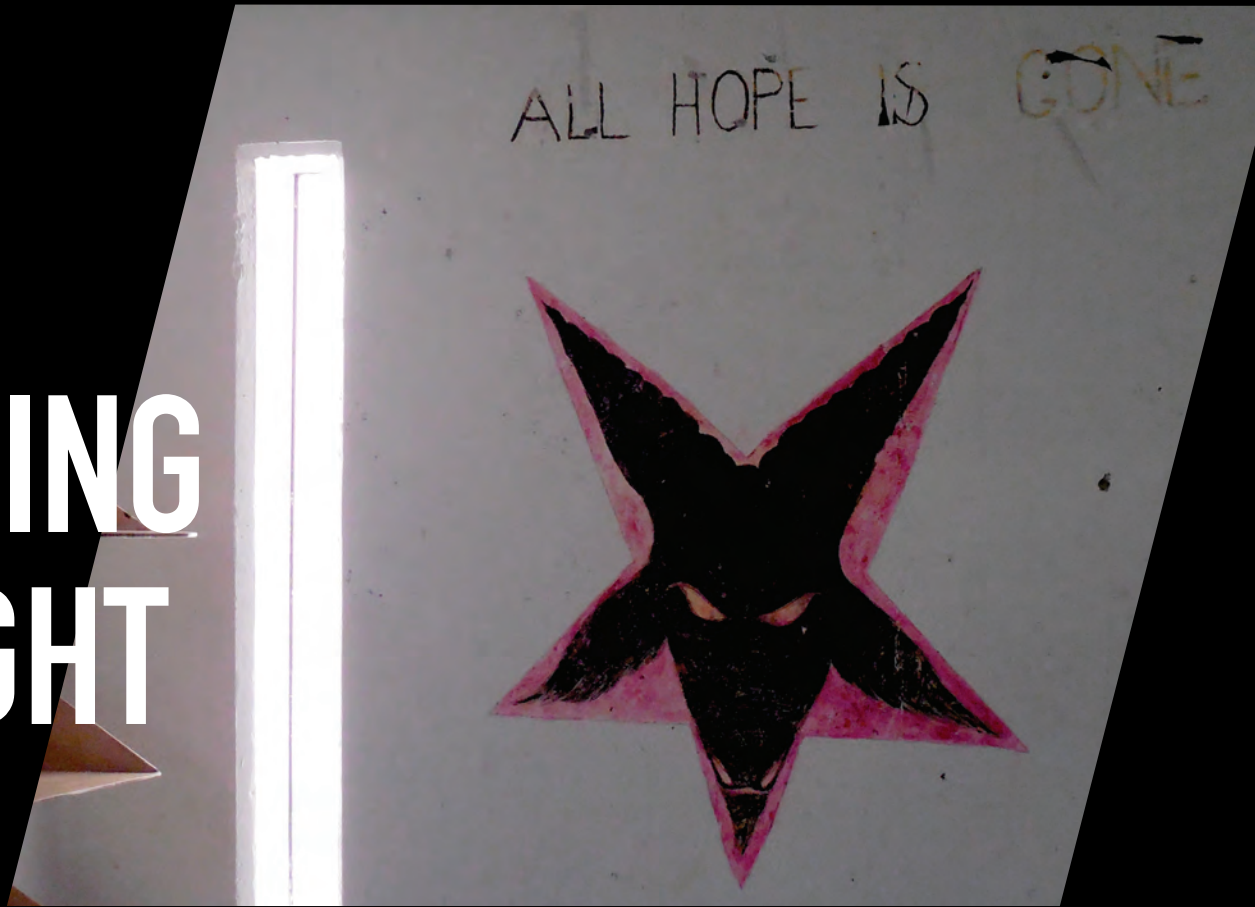


# SHINING A LIGHT ON SOLITARY CONFINEMENT

WHY OHIO NEEDS REFORM



MAY 2016



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## INTRODUCTION:

# WHAT'S HAPPENING IN OHIO PRISONS?

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Imagine you are locked inside a prison cell the size of your bathroom for 23 hours a day. You are released from this cell for one hour a day, when you are escorted to a different cage the size of a walk-in closet meant for recreation. Sometimes, perhaps on a weekend or when the weather is bad, you don't get out at all. You eat your meals in this room, just a few feet away from your toilet; you have limited access to books and televisions.

**This is solitary confinement in Ohio.**

Solitary confinement is not rehabilitative. It does not prepare people for transition to the general prison population or back into the community. It does not make prisons – or our communities – any safer.

To make matters more tragic, of the **2,952 people in solitary confinement in Ohio prisons on any given day, 743 (more than a quarter) have a mental illness.**<sup>1</sup>

**Prisons serve as the largest provider of mental health services in the state;** they serve 10 times more people with mental illness than our state psychiatric hospitals.<sup>2</sup> Instead of focusing on treatment, we use punishment – including solitary confinement – as our means of rehabilitation.

Across the country, corrections systems are rethinking solitary confinement and implementing reforms, leading to decreases in violence and cost and improvements in rehabilitation. Ohio's prisons director, Gary Mohr, has spoken out in favor of reforms and has taken steps to reduce the time that people in prison spend in solitary confinement. But we must go farther, particularly for people with mental illness.

The American Civil Liberties Union of Ohio and Disability Rights Ohio have collaborated in preparing this report. We toured Ohio prisons. We interviewed dozens of prisoners, who spoke about being crushed by the conditions of solitary confinement, about their desire for effective mental health treatment and rehabilitative programming, and about the mistreatment they experience on a daily basis. We spoke with family members, people who were formerly incarcerated, and prison staff.

These stories, coupled with a review of prison data and practices in Ohio and other states, resulted in our recommendations for reform of solitary confinement in Ohio's prisons.

**The Ohio Department of Rehabilitation and Correction has recognized problems with solitary confinement and is making plans for reform. The ACLU of Ohio and DRO commend these efforts and call on Ohioans to demand expansive reform to solitary confinement. We urge ODRC to make their reforms as strong and effective as possible.**

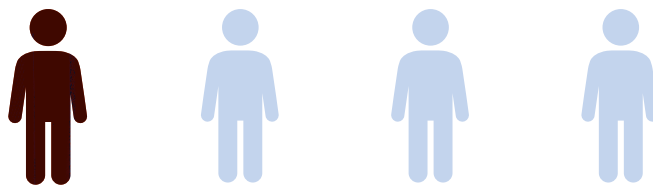
## Ohio Prisons: By the Numbers

Ohio has the **6TH LARGEST PRISON POPULATION** in the U.S.<sup>3</sup>

The majority entering Ohio prisons are between **25-29 YEARS OLD**,<sup>4</sup> and the top offense is burglary.<sup>5</sup>

A 2014 ODRC survey found **75 PERCENT** of people in prison **ARE PARENTS.**<sup>6</sup>

**MORE THAN HALF OF ALL PEOPLE** in Ohio prisons are there for the first time<sup>7</sup>



**1 IN 4 NEW PEOPLE** coming into prison for the first time **ARE THERE FOR A DRUG OFFENSE**<sup>8</sup>

There are currently **50,742 PEOPLE** in Ohio prisons **DESIGNED TO HOLD 38,600.**<sup>9</sup>

# SOLITARY CONFINEMENT IN OHIO

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Solitary confinement goes by many names in Ohio – restrictive housing, local control, disciplinary control, protective custody, or administrative segregation. No matter what you call it, solitary confinement is extreme isolation in a cell for 21+ hours a day.

Solitary confinement is often used as a first resort for minor rule violations like making too much noise, talking back to a corrections officer, testing positive for drugs, possessing too many items, awaiting transfer to a different facility, or even as housing for people who have attempted suicide.

Despite the overwhelming evidence that solitary confinement is detrimental to anyone who experiences it, does not improve safety, and is not rehabilitative, prisons still use it, though Ohio has undertaken efforts to reduce its use and provide more out-of-cell time.

Solitary confinement affects every aspect of a person’s daily life, including the amount of time allowed for recreation, visitation, phone calls, meals, and rehabilitative programming.

The chart below shows the time allotted to various activities for prisoners based on their security level. **Prisoners with a security level 5b, 5a, or 4b are in solitary confinement at all times.**

	Level 5b	Level 5a	Level 4b	Level 4a - transitional
<b>RECREATION</b>	<b>5 one-hour</b> daily periods per week, alone	<b>5 one-hour</b> daily periods per week, alone	<b>5 one-hour</b> daily periods per week, alone	<b>7 one-hour</b> daily periods per week, small group
<b>VISITS</b>	Non-contact, <b>2 visits</b> per month up to <b>2.5 hours</b>	Non-contact, <b>2 visits</b> per month up to <b>3.5 hours</b>	Non-contact, <b>2 visits</b> per month up to <b>4 hours</b>	Contact, <b>4 visits</b> per month up to <b>7 hours</b>
<b>PROGRAMMING</b>	On TV or program cells	On TV or program cells	On TV or program cells	On TV or in small groups unrestrained.
<b>MEAL SERVICE</b>	Served in cell	Served in cell	Served in cell	Small group in dining hall or in unit

Even more people are not considered in solitary, yet are spending nearly this much time in isolation.

## Solitary Confinement in Ohio’s Maximum Security Prisons

Ohio uses two maximum-security prisons as solitary confinement for prisoners classified as security level 5b, 5a, or 4b.

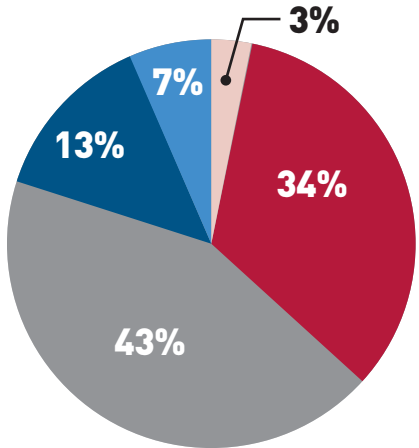
**As of March 2016, 833 people were in levels 5b, 5a, and 4b.<sup>10</sup>**

When an individual is sent to a maximum-security prison, they are in solitary confinement for a long time. **In the best of circumstances, it will be two years before they can be with other people and that is only if they receive a reduced security level at each review.**

Disability Rights Ohio surveyed prisoners currently in solitary confinement at the Ohio State Penitentiary and Southern Ohio Correctional Facility. Thirty people completed the survey. Over half have been in these maximum-security prisons for 1-5 years; four have been in the facilities for 5-10 years; and three have been in the facilities for more than 10 years.

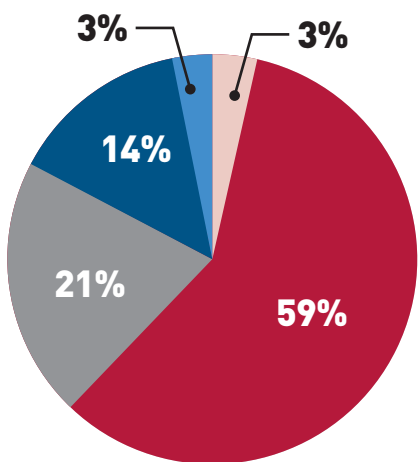
# 62% OF PEOPLE IN SOLITARY CONFINEMENT SPENT LESS THAN 1 HOUR OUTSIDE THEIR CELL IN A TYPICAL DAY.

TYPICAL AMOUNT OF TIME SPENT WITH OTHERS



- 3% None
- 34% 1-10 minutes
- 43% 10-30 minutes
- 13% 30 minutes-1 hour
- 7% More than 2 hours

AMOUNT OF TIME SPENT OUTSIDE CELL



- 3% None
- 59% Less than 1 hour
- 21% About 1-2 hours
- 14% About 2-4 hours
- 3% More than 4 hours

## Southern Ohio Correctional Facility

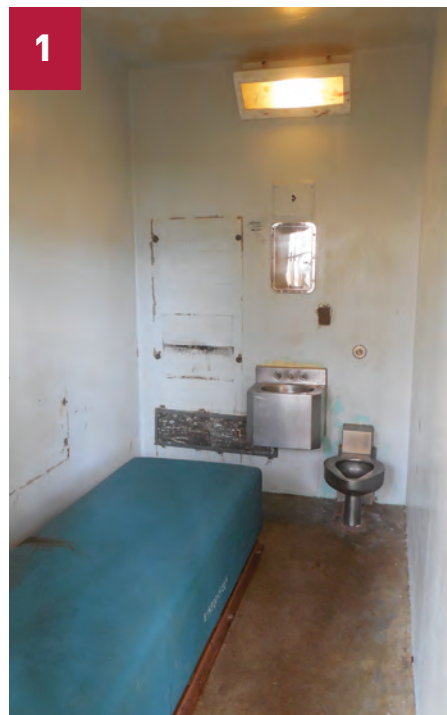
Southern Ohio Correctional Facility (SOCF) in Lucasville is a maximum-security prison built in 1972<sup>11</sup> to house people in both long-term solitary confinement and those transitioning out of solitary back into the general population. For the past seven years, SOCF has been under capacity.<sup>12</sup> Of the 1,179 prisoners at SOCF, **478 are in level 4b, which is solitary confinement.**<sup>13</sup>

Most people at SOCF are housed in large units with long rows of cells. Each unit is extremely loud as people yell to each other through the bars on the doors. The light in the cell is never turned off, and is usually kept at the “dim” setting—too bright to be comfortable while sleeping, but too dim to be useful for reading or writing.

*They’ve got the power, the authority to turn the bright light on if they wanted to but they just leave it on the dim light. It kind of messes with your mood, your feelings. The bright light will make you feel better, like brighter, like alive, but the dim light makes you feel sad and dull. It messes with me. It messes me up.*

-Ulious Brooks, prisoner at SOCF

There are no televisions in the cells for 4b prisoners. Some units have TVs outside of the cells for individuals to watch through their cell bars; the corrections officers have full control over the TVs, so they may not be on or audible.



1. Solitary cell at SOCF, and dim light that is always turned on.
2. Solitary cell at SOCF.

## Southern Ohio Correctional Facility continued

Recreation takes place in long rows of cages either in a large indoor warehouse or outside. When the ACLU toured SOCF and asked a staff member what prisoners normally do during recreation, he said that they usually take advantage of the only opportunity they have to engage in conversation with other people, even though it happens through a wire barrier. The hour of recreation starts when the guard leads a prisoner, cuffed, from their cell to the recreation cage. If that takes 15 minutes, then a person gets only 45 minutes of recreation.

Half of SOCF is used for solitary confinement and the other half for transitioning out of isolation. People spend most hours of their days in a cell, a little bit of time in a recreation cage, and even less time chained to a table for programming.



1. Outdoor recreation cage at SOCF
2. Indoor recreation cages at SOCF
3. A pod (group of cells) at OSP.
4. Narrow window in a cell at OSP. That is a mechanical pencil.



## Ohio State Penitentiary (OSP)

The Ohio State Penitentiary (OSP) is Ohio's super-maximum security prison built in 1998 in Youngstown. **OSP houses 303 people, all of whom are in solitary confinement.**<sup>14</sup> It was built on the premise that Ohio needed an even higher level maximum-security prison to house people who were deemed dangerous or unruly. However, for the past 12 years, like SOCF, OSP has been under capacity.<sup>15</sup>

This prison was built with only solitary confinement in mind. With the exception of some low-security prisoners who act as the cleaning crew, **every single person at OSP is in solitary confinement at all times.**

*"OSP is not the rehabilitation. It's the department of rehabilitation and corrections. This is the corrections end of it. It's no rehabilitation here. Because for some guys you're encouraging the same conduct that brought them here."*

*-Amondo Cole, prisoner at OSP*

Cells are arranged in units called "pods," see picture three. The tables in the middle are not used. The indoor recreation cage is to the far right. All cells have thick, solid doors instead of bars, making it difficult for people to talk to others in the unit. **The lights are never turned off in a cell,** regardless of whether it is time to sleep. Windows are small – not even as wide as the length of a mechanical pencil. Some windows face a concrete wall.





**People incarcerated at OSP spend 23 hours a day in their cell; two days each week they are not released from their cells at all.**

When they leave their cell it is either for a **15-minute shower three times a week** or for **one hour of recreation five days a week**. Recreation can be either inside or outside, weather permitting. At OSP, indoor recreation is simply leaving one cell to enter a different one about 50 feet away.



*Yeah, I go to rec but what's the point of me going to recreation when it ain't nothing but me leaving my cell and go into this cell?*

*-Bobby Williams, prisoner at OSP*

Each time a person is taken out of their cell to visits, to sit in a programming cage, or to medical care, they are strip-searched in a cage before being placed back into their cell. Each time a person exits their cell, they are handcuffed, put in leg shackles, and both wrist and ankle shackles are connected to a belt around the stomach.

If a person needs medical care, they are placed in a medical cage.

1. Solitary cell at OSP
2. View from inside treatment cage at OSP.
3. Indoor recreation cage at OSP.
4. Strip search cage at OSP.

## Solitary Confinement in Ohio's Medium Security Prisons

In addition to solitary confinement at the two maximum-security prisons, *all* other Ohio prisons utilize solitary confinement, called local control, disciplinary control, administrative segregation, or short-term restrictive housing. Even the maximum-security prisons have local solitary confinement units they use.



On average, there are **79 people (21 with a mental illness)** in solitary confinement every day at each of Ohio's 27 prisons.<sup>16</sup>



1. Sink, toilet, shower in solitary cell at Mansfield.



2. Crisis/suicide watch solitary cell at Mansfield.



3. Narrow window in cell.

4. Outdoor recreation area at Mansfield's solitary unit.

Of the people housed in local solitary confinement units at each prison, 32 percent are in solitary confinement for more than a month.<sup>17</sup> About 51 percent of people in solitary confinement are black and 46 percent are white.<sup>18</sup>

**There are 205 people in solitary confinement at any given day at Mansfield Correctional Institution**, a facility with one of the highest number of people in isolation in Ohio prisons.<sup>19</sup> The Correctional Institution Inspection Committee (CIIC) rated Mansfield's segregation as needing improvement.<sup>20</sup>

The outdoor recreation unit looks different from that of a maximum-security prison.



# LOCKED UP, ALONE & MENTALLY ILL

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Putting people in isolation is devastating and makes recovery next to impossible. If you did not have a mental illness going into isolation, it is likely you will when you are released. Even if you have no prior history of mental illness, people subjected to prolonged isolation may experience depression, anxiety, hallucinations, or problems with impulse control or their ability to think, concentrate, or remember.<sup>21</sup>

**A federal judge said putting people with mental illness in solitary confinement is the mental equivalent of putting an asthmatic in a place with little air to breathe.<sup>22</sup>**

ODRC recognizes these risks. All people placed in level 5 for more than a year are given an elevated monitoring status by mental health professionals, regardless of whether they have a mental illness. The elevated monitoring is intended to catch signs of deteriorating mental health and to intervene before it becomes severe.

## Mental Health Classification

In Ohio, individuals receive one of three mental health classifications: C1, serious mental illness; C2, on the mental health caseload but not a serious mental illness; or N, not on the mental health caseload.

Every prisoner is assessed upon entering prison, when transferring between facilities, and when a staff member makes a recommendation. A treatment plan is required for every person on the mental health caseload. If a person meets the criteria and needs higher-level mental health care for a very

serious mental illness, they can be placed in a residential treatment unit (RTU). SOCF has one RTU, but prisoners in solitary confinement with a high security classification often cannot receive services in the RTU.

ODRC policy states that every person in solitary confinement is to be seen by a mental health professional every seven days. If a person in solitary confinement has a severe mental illness (C1) and has been there for 30 days, a treatment team is convened to develop a plan and will continue to meet every 30 days.

*On the outside, I had a therapist and I had the psychiatrist, the one who gave me the medications. Both of them were attentive and listened to what I had to say. It's hard to get through something here, because you don't have the therapy time. You just get the medications. ... I'll go lay down, and I'll just cry. I don't know what else to do. I still do sometimes when it gets frustrating. It's hard when you got a problem and you try to communicate with somebody and they just don't give a crap.*

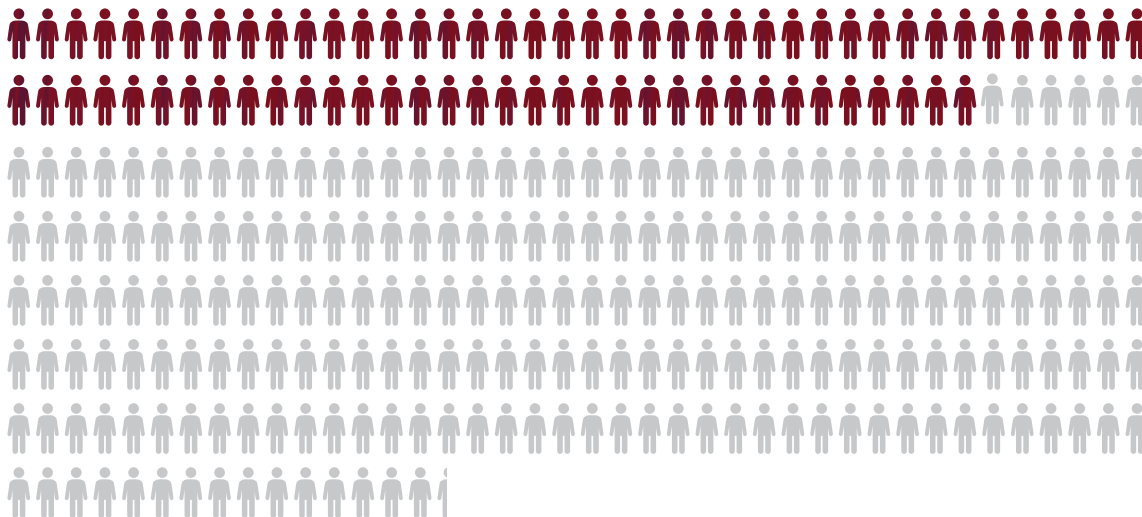
*-Robert Harmony, prisoner at SOCF*

## Placement in Solitary Allowed

**THERE IS NO BAN ON PEOPLE WITH A MENTAL ILLNESS BEING LOCKED AWAY IN ISOLATION FOR ANY AMOUNT OF TIME.**

**Persons with mental illness often have difficulty complying with strict prison rules**, particularly when there is scant assistance to help them manage their disorder.<sup>24</sup> This can lead to more rule violations that result in more time in solitary confinement; it can become a never-ending cycle.

OSP and SOCF have a significantly higher percentage of people with mental illness compared to Ohio's other prisons.<sup>25</sup>



**Of the 2,952 people in solitary confinement in Ohio, 743 of them have a mental illness.<sup>23</sup>**

 = 10 people

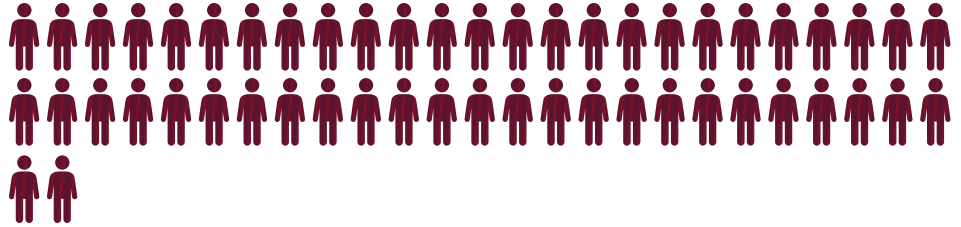
Due to an ACLU lawsuit, people with serious mental illness (C1) cannot be housed at OSP unless specifically approved by ODRC. **However, even though people with a serious mental illness (C1) are not housed at OSP, there are still 52 people (17% of OSP's population) with a documented mental illness.**<sup>26</sup>

**At SOCF, 376 people (31% of the prison's population) are treated for mental illness; 156 people have a serious mental illness.**<sup>27</sup>

Across the board, individuals with mental illness are disproportionately in solitary confinement. Twenty-three facilities out of 27 have a greater percentage of people who are on the mental health caseload in solitary confinement, compared to the mental health caseload of the general institution population.<sup>28</sup>

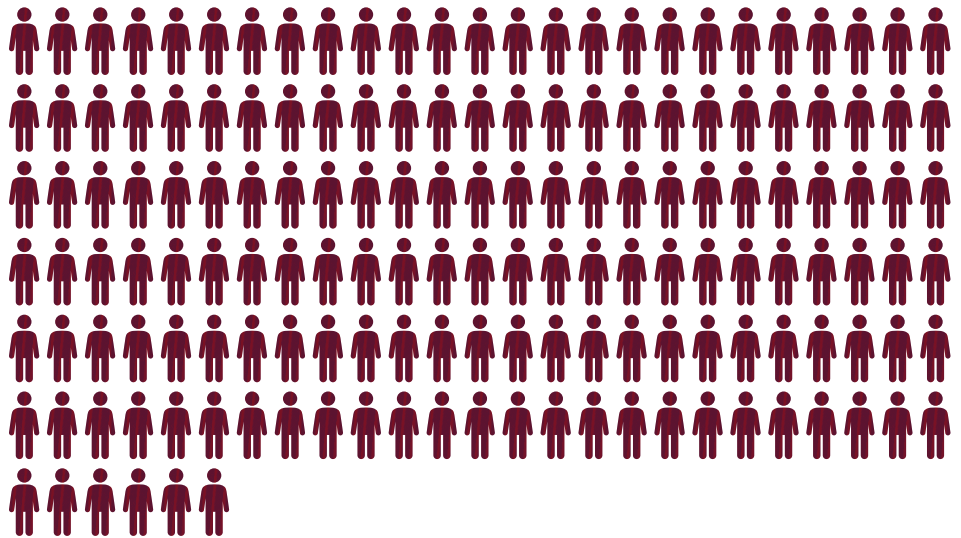
**OHIO STATE PENITENTIARY (OSP)**

**52 people with a documented mental illness.**



**SOUTHERN OHIO CORRECTIONAL FACILITY**

**156 people have a serious mental illness.**



## Lack of Treatment and Programming

Despite the large numbers of individuals with mental illness in solitary confinement and the detrimental impact of solitary confinement on mental health, effective mental health treatment is lacking in Ohio's solitary confinement units. When asked in our survey about what services they receive, many individuals with mental illness at SOCF and OSP stated that services were not consistent.

For ODRC as a whole, the average cost per day for a prisoner is \$61, only \$3.06 of which is spent on mental health and recovery services.<sup>29</sup>

As we interviewed people, they told us over and over again about their desire for more effective mental health treatment. But instead, they are offered worksheets to complete and materials to review about anger management or changing their perspective. Mental health staff do not meet with them to review their answers to the questions, and they are often awarded credit for completing the programs even if they failed to answer the questions correctly.

*“They pass out a packet to you and tell you they going to reward you with a picture or reward you with something if you do it. I don’t even answer the questions. I just flip through and write anything ... People even pay me, when I take they stuff, and I’ll write in my handwriting anything on the stuff and give it back to the person and he’ll pass. They don’t even look at it. They don’t even look at the stuff.”*

*-Anonymous, prisoner at SOCF*

Even when people in prison are offered counseling or meetings with mental health staff, they are not able to take full advantage of the opportunities. Corrections officers are often present for programming and individual meetings between the prisoner and mental health staff, despite prisoners' concerns about confidentiality.

**Lack of Treatment and Programming continued**

Because of an ACLU lawsuit, *Wilkinson v. Austin*, the cells at OSP have a television in them. **Most of the reentry, mental health, and substance abuse programming offered to individuals is simply recorded programs shown on television.** When not using the television, limited rehabilitative programming takes place in cages where six people can participate at a time.

Similarly, rehabilitative programming at SOCF happens while tethered by handcuffs to a table with four people at a table at one time. For any reentry or mental health programming requiring more mobility, they will place the person in a cage.

*We have nothing to occupy our minds. All we can do is sit, think, and let our head play tricks on us. Sometimes there is video group where we watch National Geographic animal videos and draw. The whole mental health system is horrible at SOCF. I sit in my cell all day and think. I try to block out the voices I hear. My meds help a little, but not all the way. I feel like the walls breathe sometimes, and the cell gets smaller. The isolation drives me crazy. It traps me with my thoughts, and I'm my own worst enemy.*

*–David Cooper, prisoner at SOCF*

People in solitary confinement aren't the only ones who are affected by the lack of treatment and programming. Correctional officers must attempt to respond to prisoners' needs, often without the training or resources to do so.

*“People need proper diagnosis when they enter prison. Those mental health issues are exacerbated by incarceration. Officers don't usually know until the prisoner goes off the deep end, and then it's a real security problem.”*

*–Anonymous Ohio Corrections Officer*



**OSP Television Program Schedule**

Time	Ch3 Religious Services (8/9/15-8/15/15)	Ch3 Religious Services (8/16/15-8/22/15)	Ch7 MH & Edu (8/9/15-8/15/15)	Ch7 MH & Edu (8/16/15-8/22/15)	Ch9 Rec Serv & Med (8/9/15-8/15/15)	Ch9 Rec Serv & Med (8/16/15-8/22/15)
9:00AM						World's most dangerous drug
9:30AM						
10:00AM						American meth
10:30AM	Teach us how to pray	Teach us how to pray				
11:00AM	Hope channel	Hope channel	Hope channel	Hope channel	Hope channel	
11:30AM	The pistol	The Da Vinci delusion			Getting there - humor in tx	World's most dangerous drug
12:00PM						
12:30PM		The four chaplains	Suicide prevention	Suicide prevention	The anonymous people	American meth
1:00PM						
1:30PM	Love not the world	Mass for shut ins				
2:00PM			PREA	PREA		World's most dangerous drug
2:30PM	Clash of the titans	Audio CD benefits of tribulation			Getting there - humor in tx	
3:00PM			RET	RET		American meth
3:30PM						
4:00PM		Hope channel	Hope channel	Hope channel	Hope channel	
4:30PM	Teach us how to pray	Teach us how to pray	RET	RET	The anonymous people	World's most dangerous drug
5:00PM	Courageous	Walk the walk				
5:30PM			Military veterans	PREA		American meth
6:00PM		The prodigal returns				
6:30PM				Military veterans	Getting there - humor in tx	
7:00PM			RET	RET		World's most dangerous drug
7:30PM					The anonymous people	
8:00PM	The passion of the Christ	The Da Vinci delusion				American meth



1. Programming cages at OSP.
2. Typical television program schedule at OSP.
3. Programming cages and tables at SOCF.



## Higher Risk of Suicide

In a survey, 27 percent of people in solitary confinement reported suicidal thoughts, which is significantly higher than in the general prison population.<sup>30</sup> In fact, when Disability Rights Ohio toured the solitary confinement units at Mansfield Correctional Institution, they were shown a cell that had been empty for a while. There was still a noose hanging from the ceiling that had yet to be removed.

*“We are on the mental health caseload, but we’re still humans. We need help, but the way they deal with it is to trap us in a box 23 hours a day. I just spent the last three days in my cell without exiting one time. This explains why so many people hurt, harm, and kill themselves in confinement... I know how it is to be so lonely that death doesn’t seem so bad.”*

*–Adam Patrick Robinson, prisoner at SOCF*

**People who were ever assigned to solitary confinement are 6.9 times more likely to commit acts of self-harm.<sup>31</sup>**

**In California, 73 percent of all suicides occurred in isolation units. In Indiana, the rate of suicide was almost three times higher in isolation than other units.<sup>32</sup>**

**Of all Ohio prisons, SOCF has had the most suicides since 2000.<sup>33</sup>**

**In Ohio, suicides are more common in solitary confinement cells.<sup>34</sup>**

Even more concerning are reports from prisoners who are punished for self-harm or attempting suicide, even though these acts are manifestations of their mental illness. This practice is not therapeutic and does not address the underlying cause of the person’s self-harm.

*I got a ticket for swallowing a razor blade. I got two tickets for trying to hang myself and they put me on phone restrictions, so I couldn’t talk to my family after I did it.*

*–Al George, Prisoner at SOCF*

Noose found in solitary cell at Mansfield Prison.

# PROBLEMS WITH SOLITARY CONFINEMENT

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Research and experience demonstrate that solitary confinement is a costly system that does not increase the safety of our prisons or our communities. There are also inherent risks of prisoner abuse, borne out in racial disparities and the arbitrariness of solitary confinement placements.

*“Research still confirms what this Court suggested over a century ago: Years on end of near-total isolation exacts a terrible price... Prisoners are shut away—out of sight, out of mind.”*

*-U.S. Supreme Court Justice Anthony Kennedy <sup>35</sup>*

The United Nations Special Rapporteur states that **psychological damage from solitary confinement can become irreversible after just seven days.**<sup>36</sup> A person’s need for meaningful interaction with other humans and purposeful activity is like a person’s need for food. Without enough, they suffer and deteriorate.<sup>37</sup>

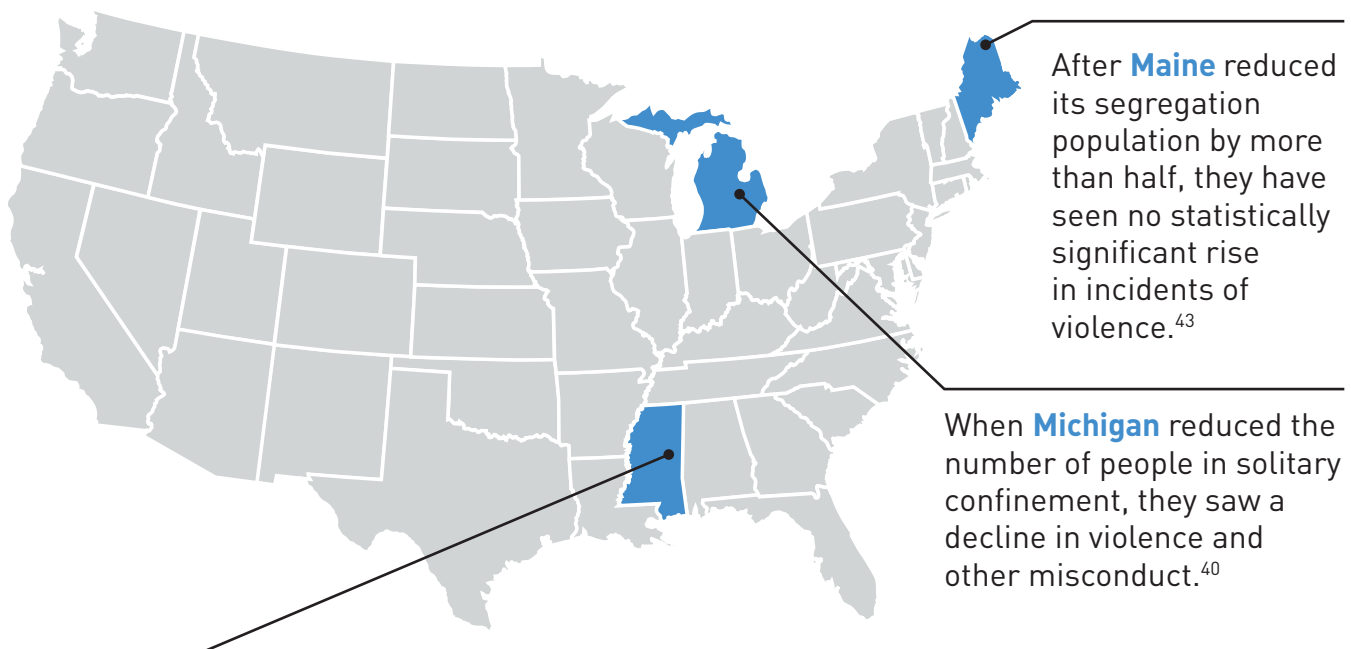


## Solitary Confinement is Costly and Does Not Make Prisons Safer

Solitary confinement is the most expensive form of confinement. A super maximum-security prison costs two to three times as much as a conventional prison.

EACH DAY, IT COSTS **\$139** PER PRISONER FOR OHIO'S TWO MAXIMUM-SECURITY PRISONS, COMPARED TO **\$54** AT MINIMUM TO MEDIUM-LEVEL FACILITIES.<sup>38</sup>

By contrast, corrections officials in Mississippi estimate that diverting people from solitary confinement saves \$8 million annually.<sup>39</sup> **Taxpayers expect to pay for a system that works. Yet despite its increased costs, solitary does not make prisons safer. In fact, research shows that decreasing the use of isolation reduces violence.**



Solitary confinement is not effective or necessary. But, some proponents still describe why they think solitary confinement is necessary by telling personal stories or by recounting a horror

story of a violent incident in a prison. But, there is a reason that their arguments rely on anecdotes: **the evidence is overwhelming that solitary does not make a prison safer.**

ODRC itself recognizes the severity and the dangers of the solitary confinement experience: In maximum-security prisons, they move people from solitary confinement to a transitional unit (4-AT) before returning them to the general population.

## Solitary Confinement Does Not Make the Public Safer

**MORE THAN 95% OF PEOPLE WHO GO TO PRISON ARE ONE DAY RELEASED BACK TO THEIR COMMUNITIES.<sup>44</sup>**

In Ohio, more than 21,000 people are released *each year*.<sup>45</sup> Therefore, the conditions in our prisons impact the conditions of our communities. Prisons should be places of rehabilitation, helping to return people to the community better than when they arrived.



In 2013, OSP released **66 PEOPLE** back to the community directly from solitary.



In 2014, they released **80**.<sup>46</sup>

In 2013, SOCF released **280 PEOPLE** back to the community. In 2014, they released **221**. These are people from solitary and transitioning out of solitary confinement.<sup>47</sup>

Mansfield Correctional Institution has one of the largest number of people in solitary confinement in Ohio. In 2013, they released 845 people back to the community. In 2014, it was 964.<sup>48</sup> ODRC does not keep data about how many were directly released from solitary confinement.

Facility	SOCF	OSP	MANSFIELD
Top Counties of Commitment for Those Released in 2014	Cuyahoga <b>59</b> Hamilton <b>26</b> Franklin <b>19</b> Montgomery <b>12</b> Lucas <b>11</b>	Cuyahoga <b>36</b> Franklin <b>5</b> Summit <b>9</b>	Cuyahoga <b>299</b> Summit <b>106</b> Stark <b>71</b> Franklin <b>36</b> Richland <b>33</b>

*Compiled from ODRC Release Summary data*

Multiple studies show higher recidivism for individuals who were previously in solitary confinement.<sup>49</sup> In other words, the use of solitary confinement in our prisons makes crimes in our communities more likely. People in prison in Arizona who spent a long time in solitary confinement reported “difficulty adjusting to a regular prison yard... adjusting to life outside a prison environment can feel utterly impossible.”<sup>50</sup>

*“I’m going to hurt somebody. That’s just me being honest man. I hate to admit it though, but if I had to do the rest of my time, because I got so much anger and mental problems, I don’t think I’ll last long out there. ... I ain’t got no, ain’t no programs or nothing. What I’m supposed to do out there? I don’t know nothing about the free world. That’s sad to say, but that’s true. I don’t know where to start or where to end.”*

*-Anonymous, Prisoner at OSP*

## Abuses, Racial Disparities, Arbitrary Placement Decisions

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People placed in solitary confinement are often in a prison within a prison, locked away from oversight and accountability. The belief that segregation houses the “worst of the worst” makes it more likely that people will ignore or turn a blind eye to abuses. As a result, a person’s hostility toward prison staff and society in general increases.<sup>53</sup>

During our investigation, we received numerous reports of abuses, harassment, and retaliation by correctional officers and facility staff against people in solitary confinement. Because these prisoners are isolated, there are rarely witnesses to the abuses, so prisoners’ complaints are routinely ignored or found to be unsubstantiated. The complaints we received ranged from deprivation of rights—such as receiving empty food trays, having the plumbing turned off in their cells, and denial of recreation or phone calls—to unprovoked use of force, especially by pepper spray.

*Just picture it, if you was in a cell and you got a CO retaliating on you all hours of the day, refusing you food, searching your cell, tearing up your stuff, cussing you out, pepper spraying you for no reason, just all different type of stuff and you just in that cell. You’re taking all this abuse. You got guys that aren’t equipped mentally to deal with that so they be angry. They lash out, they cry, they holler, they scream, they cuss us guys out for no reason because they angry. You got a lot of guys like that. That’s what solitary confinement do, that’s what it do to the mind...Destroys the mind.*

*-Jerone McDougald, prisoner at SOCF*

It follows then that giving people more human interaction, like increased visitation, lowers recidivism. In fact, the more visitations, the lower a prisoner’s odds of recidivating.<sup>51</sup> Yet, solitary confinement reduces or eliminates visitation entirely. At OSP and SOCF, visitors may not have physical contact with prisoners, regardless of whether or not it is necessary for safety.

Prison education programs and vocational training have also been shown to significantly lower recidivism, but individuals in solitary confinement have much less access to these programs. In fact, a meta-analysis report found that every \$1 spent on educational and vocational programming resulted in savings of \$4-5 during the first three years post-release.<sup>52</sup> In other words, solitary confinement is 2-3 times more expensive and does not work; whereas increased programming saves money and *does* work.

Corrections staff wield significant control over whether people in prison are placed in solitary confinement, meaning placements can be arbitrary and not based on a legitimate determination that the person is dangerous. African Americans make up 46 percent of low to medium-security male prisoners in Ohio, yet they are 62 percent of the maximum-security population.<sup>54</sup>

Further, solitary confinement can be used as a tool of first resort for minor violations like disobeying an order, positive drug test, offensive language, or indecent exposure. Two recent examples demonstrate this arbitrariness:

- In May 2015, some people in prison at OSP went on a hunger strike. The ACLU of Ohio began talks with ODRC to see how this hunger strike could end peacefully. At the time, there were 69 people in 5b, the most restrictive level of long-term solitary confinement.<sup>55</sup> ODRC conducted reassessments on everyone in this level to see if they really needed to be there. **61% were moved down immediately, meaning there was no reason found to keep them in level 5b.** Since this time, ODRC has continued to reassign people, and as of March 1, 2016, there is no one in level 5b.
- When the Correction Institution Inspection Committee toured Mansfield’s segregation unit, they discovered that a corrections officer took away a person’s recreation—typically the person’s only opportunity to leave his cell for days or weeks at a time—because he kicked the door too hard when asking for toilet paper.

# REFORMING SOLITARY CONFINEMENT

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## REFORMING SOLITARY WORKS

In Ohio and across the country, correctional systems are proving that alternatives to solitary confinement are more effective at addressing problems within the prisons and preparing people to return to the community.

The Ohio Department of Youth Services, which is responsible for overseeing the incarceration of youth at state facilities, is a leader in reducing the use of solitary confinement. They implemented an initiative called “Pathways to Safer Communities,” which led to an 89 percent decrease in seclusion hours from 2014 to 2015, while acts of violence decreased 22 percent.<sup>56</sup> They trained their staff on trauma-informed care, motivational interviewing, and using a new set of incentives.<sup>57</sup>

## Definitions

### Trauma-informed care:

Recognizing that a traumatic event, like war, physical or sexual abuse, maltreatment, loss of a loved one, or experiencing community violence, can interfere with a person’s ability to cope. Trauma informed care means that an organization or system recognizes the role trauma has played in people’s lives and adjusts their interventions appropriately.

### Motivational interviewing:

A client-centered approach to therapy that puts the person in charge of driving the change.

### Incentives:

The emphasis is on promoting the positive behavior you want to see instead of only punishing the behavior you don’t want to see.

Colorado has reformed its system in ways that make the state a national leader in reducing and eliminating the use of solitary confinement. In just five years, the solitary population went from more than 1500 to 160.<sup>58</sup> When they began, a staff member warned, “These reforms are going to get someone hurt or killed.”<sup>59</sup> That same staff member, a year later, said that they could not believe the changes in the prisoners’ behavior and participation in the treatment. Colorado offered corrections officers and clinical staff de-escalation rooms for timeout, and they are trained regularly on mental health and trauma awareness.

In Maine, staff are trained to look for ways to defuse situations before rule violations occur. They were able to reduce the solitary population by more than half.<sup>60</sup> A *Criminal Justice and Behavior* article found that behavioral treatment programs reduced misconduct more than non-behavioral programs, by a large margin.<sup>61</sup> It goes on to state that “the higher the therapeutic integrity of a program, the more impact it had on reducing misconducts.”

*When I began, we had more than 200 mental health beds. State budget cuts drastically reduced the number of beds we could offer prisoners; this was felt throughout the prison. They gave officers the tools to identify mental health problems, but not the training to diagnose and deal with it.*

*-Anonymous Ohio Corrections Officer*

# PROPOSED REFORMS

It is time for Ohio to respond to the overwhelming evidence that solitary confinement is unsafe and ineffective—especially for people with mental illness—and to implement reforms that will make Ohio a national leader.

ODRC has taken steps forward by employing presumptive release, which allows prisoners to reduce their security level months or years earlier than under prior policies. However, these steps alone do not go far enough to protect people with mental illness and other vulnerable people from the destructive impact of solitary confinement. ACLU of Ohio and DRO encourage the Ohio Department of Rehabilitation and Correction to make their reforms as strong and effective as possible.

Therefore, we recommend the following reforms.

## Reduce Reliance on Solitary Confinement

- Utilize solitary confinement of any length as a last resort, only after less restrictive interventions have been tried.
- Prohibit solitary confinement for retaliation, staff convenience, to mitigate facility overcrowding, or as a substitute for an active medical or mental health treatment program.
- Presume that a person with a mental illness or an intellectual disability violated a rule because of their disability and will not be placed in solitary confinement. Instead, they will be transferred to a residential treatment unit where an interdisciplinary team is assembled to provide programming and rehabilitative services.
- Exclude all vulnerable populations from solitary confinement, including those under age 18, people with current or a history of mental illness (both C1 & C2), people with intellectual and developmental disabilities, people with a physical disability, and anyone who is pregnant.

## Decrease the Length of Stay in Solitary Confinement

- Define solitary confinement as any placement in which a person is confined to their cell for 21 or more hours a day. This includes all 5b, 5a, 4b prisoners, short-term restrictive housing, limited privilege housing, local control, disciplinary control, administrative segregation, crisis/suicide watch, medical observation, protective custody, and any other form of confinement for 21+ hours a day, regardless of the label.
- Hold a hearing within seven days of placement in solitary confinement to see if the individual can return to general population.
- Conduct a mental health evaluation for every person within 24 hours of placement in solitary confinement. Continue these assessments at regular intervals throughout a person's stay in solitary confinement.
- When solitary confinement is used to address offenses meant to cause serious injury or very severe offenses like an escape, limit stays to 15 or more days, but not to exceed 30 days. Require any stay of 15 or more days to be affirmed by the regional director for that facility. Any stay over 30 days would be affirmed by ODRC.
- For any stay over 14 days in solitary confinement, assemble an interdisciplinary team to create a plan to transfer the person out of solitary confinement.
- Conduct security and privilege level reviews, affirmed by ODRC, at least every 30 days for people placed in solitary confinement 30 days or more.
- Implement presumptive release so that no one stays in higher-security settings (solitary confinement) for longer than 180 days, even if the person had a previous violent offense.
- Release individuals from solitary confinement as soon as there is no longer an immediate danger to self or others.

## Increase Programming and Out-of-Cell Time in Solitary Confinement

- Improve rehabilitative and mental health programming in all types of solitary confinement, and provide it in the least restrictive manner possible with trained staff. Accountability measures should be in place to evaluate the content, frequency, and effectiveness of programming.
- For people in solitary confinement, provide at minimum 10 hours of structured programming (such as mental health group therapy) and 10 hours of unstructured time each week, both out-of-cell, in addition to time for recreation and personal hygiene. This recommendation follows the current policy for structured and unstructured programming for prisoners with mental illness in the residential treatment units.
- Address conditions of confinement, including sufficient access to natural light, ability to control the light in their cells, access to fresh air, access to reading material, and access to the law library.
- Provide all people in solitary confinement with at least 60 minutes of recreation every day and 30 minutes for a shower and shaving each day, as well as immediate access to a shower after each exposure to pepper spray or chemical agents. These times should not overlap and should be at reasonable hours throughout the day with ample opportunity for the person to participate. For instance, if it takes 20 minutes to escort people to recreation, the hour begins once they are in the recreation areas. Accountability measures such as individual documentation with daily supervisory review should be in place to ensure people are receiving adequate time for recreation and personal hygiene.

## Add Step-down Units Before Release from Solitary Confinement

- Create step-down units to ensure a smooth transition for people returning to the general population or being released to the community. The step-down program should be one that increases the time out-of-cell and provides monitored group interaction, visits, and phone calls.

## Improve Data Collection

- Collect data on the use of solitary confinement, including: race, gender, age, underlying offense, cause for placement in solitary classification, less restrictive interventions that were tried first, length of time, release and transition details, and outcomes after release. This data should be reported monthly on the ODRC website.
- Hire an independent monitor to ensure reforms are implemented successfully. Across the country, corrections officials and advocates have been looking for a model that works. No one has independent, evidence-based reforms to share. Ohio should be a leader in this area.

## Enhance Staff Training

- Ensure staff are trained on mental health treatment, trauma-informed care, and de-escalation techniques, along with alternatives to solitary, including incentive-based programming. Reform happens only when staff understand and believe in what is happening. It is unfair to take away the only paradigm staff have been taught and not provide the tools to help them succeed under a new model that drastically reduces the use of solitary confinement.

## Strengthen Legislative Oversight and Support

- Empower the Correctional Institution Inspection Committee to evaluate the implementation of solitary reform efforts and recommend legislative changes to codify these reforms. It is the responsibility of the legislature to provide oversight to the prison system, and its standing committee is well-positioned to review ODRC's reforms.
- Fund programming and staff training to implement these reforms. These reforms are only as powerful as the legislature's support. Increased programming and training will cost money at the front end, but the state will realize savings through decreased prison violence, reduced use of solitary confinement, and a decrease in people coming back to prison.

# CONCLUSION

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Solitary confinement — for people with or without mental illness — often amounts to cruel and unusual punishment. It aggravates mental illness for those previously diagnosed, and may lead to a diagnosis of mental illness for those who previously did not have it.

Ohioans spend \$1.5 billion on our prisons annually,<sup>62</sup> yet we are not getting a return on our investment. People are released from prison often in worse condition than when they went in, especially when they have been subjected to solitary confinement. They are unprepared to lead productive lives as citizens, and their mental health problems may have worsened.

**For every \$1 spent on prison education programs, states save \$4-5 during the first three years post-release.<sup>63</sup>**

By reforming our solitary confinement practices and focusing on treatment and rehabilitation, we can return people from prison to their communities ready to participate fully in life. They – and we – will be the better for it.

*“Why do we need to do this? It is the right thing to do if we want to achieve safer institutions and communities. First, it is our belief that those lengthy periods of 23 hours per day in confinement multiplies a problem, not solves it. At best, it suspends it. Second, we believe lengthy stays manufacture or increase mental illness. If 95 percent or more of our inmates are returned to the community, we have an obligation to return them in a better condition to be law-abiding citizens.”*

*-ODRC Director Gary Mohr & Rick Raemisch<sup>64</sup>*



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# SHINING A LIGHT ON SOLITARY CONFINEMENT

## WHY OHIO NEEDS REFORM

For more information, contact The American Civil Liberties Union of Ohio or Disability Rights Ohio.

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