UNITED STATES DISTRICT COURT
DISTRICT OF NEBRASKA

HANNAH SABATA, et. al, **Plaintiffs,** **v.** **NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES, et. al,** **Defendants.**	**Case No. 4:17-cv-03107-RFR-MDN** **CLASS ACTION** **EXPERT DECLARATION OF CRAIG HANEY, PH.D., J.D., IN SUPPORT OF CLASS CERTIFICATION**

I, Craig Haney, Ph.D., J.D., declare as follows:

I. Expert Qualifications

1. I am a Distinguished Professor of Psychology and the UC Presidential Chair at the University of California, Santa Cruz. 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 solitary or "supermax"-type confinement. In addition to these scholarly articles and book chapters, I have published two 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).

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 consequences of 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 on jail- and prison-related issues. Those agencies and organizations include the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, the United States Department of Justice, the Department of Health and Human Services (HHS), the Department of Homeland Security, and the White House (under both the Clinton and Obama Administrations). In 2012, I testified as an expert witness before the Judiciary Committee of the United States Senate and was appointed as a member of a National Academy of Sciences committee analyzing the causes and consequences of high rates of incarceration in the United States. (A copy of my curriculum vitae is attached to this Declaration 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, 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 settings, and specialized correctional housing units (such as solitary and "supermax"-type confinement). 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, Illinois, 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), and prisons in Canada, Cuba, England, Hungary, and Mexico. I also have conducted numerous interviews with correctional officials, guards, and prisoners to assess the impact of penal confinement, and statistically analyzed aggregate data from numerous correctional documents and official records to examine the effects of specific

[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).

conditions of confinement on the quality of prison life and the ability of prisoners to adjust to them.[2]

7. I have been qualified and have testified as an expert in various federal courts, including United States District Courts in Alabama, Arkansas, California, Georgia, New Mexico, Pennsylvania, Texas, and Washington, and in numerous state courts, including courts in Arizona, 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 the California Supreme Court, and by Federal District Courts, Circuit Courts of Appeal, and the United States Supreme Court.[3]

II. Nature and Basis of Expert Opinion

8. I have been retained by counsel for the plaintiffs in Sabata v. Nebraska Department of Correctional Services, et al. to provide expert opinions on three inter-related

[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, in D. Canter & R. Zukauskiene (Eds.), Psychology and Law: Bridging the Gap (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, Demonizing the "Enemy": The Role of Science in Declaring the "War on Prisoners," Connecticut Public Interest Law Review, 9, 139-196 (2010); 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).

[3] For example, see Brown v. Plata, 563 U.S. 493 (2011); see also **Exhibit 1** for a list of cases citing my work.

topics: a) a summary of what is known about the negative psychological consequences of solitary or isolated confinement (or what is known in Nebraska as "restrictive housing"); b) an explanation of whether and how those negative consequences can be exacerbated for prisoners who are suffering from serious mental illness ("SMI");[4] and, finally, c) based on the case-specific discovery that I have been provided and reviewed, the extent to which prisoners housed in the Nebraska Department of Correctional Services ("NDCS"), including those who suffer from SMI, are subjected to solitary-type confinement that may place them at a serious risk of psychological harm.

9. My opinions on these topics are based on a number of sources. In addition to my own direct experience interviewing and evaluating prisoners housed in restrictive housing

[4] The NDCS regulations offer two generally similar but non-identical definitions of serious (or major) mental illness. Administrative Regulation ("AR") 210.01 defines "serious mental illness" as "[a]ny mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to (1) schizophrenia, (2) schizoaffective disorder, (3) delusional disorder, (4) bipolar affective disorder, (5) major depression, and (6) obsessive compulsive disorder." NDCS025022. This regulation cites to NEB. REV. STAT. § 44-792, which defines serious mental illness the same way. However, AR 115.23 VI defines "major mental illness" as a DSM-V diagnosis of one of a number of disorders, or as a DSM-V diagnosis of one of the following, with high severity (i.e., significant functional impairment): "Depressive Disorder, other Mood Disorder, Posttraumatic Stress Disorder, Obsessive Compulsive Disorder, Panic Disorder, or other Anxiety Disorder". PLAINTIFF0006671. Here I rely on the definition of serious mental illness or SMI in operation in AR 210.01. Generally, it includes persons with a current diagnosis or significant recent history of types of DSM-IV-TR Axis I diagnoses (including schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, brief psychotic disorder, psychotic disorder not otherwise specified, major depressive disorders, and bipolar disorder I and II); persons who suffer from other diagnosed Axis I psychiatric disorders commonly characterized by breaks with reality, or perceptions of reality, or that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health; and persons diagnosed with severe personality disorders that are manifested by episodes of psychosis or depression, and result in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

(including some who were suffering from SMI) in Nebraska, I reviewed the extensive published literature that addresses the psychological effects of solitary confinement. In addition, I requested and have been provided with a set of official documents that pertain to the use of solitary confinement within the NDCS. The discovery documents that I reviewed include: various official NDCS documents (including administrative regulations pertaining to restrictive housing and special needs inmate programs, annual reports, operational memoranda, and Inmate Handbooks); portions of the institutional files (including the mental health records) and document summaries for the prisoners whom I interviewed at each facility; and several overview reports [including the NDCS Restrictive Housing Report (dated September 14, 2018),[5] the 2017/2018 Office of Inspector General Annual Report on the Nebraska Prison System [hereinafter OIG Annual Report],[6] and an Office of Inspector General Supplemental Report on the Nebraska Penitentiary (dated October 11, 2018[7])]. A document index that contains a detailed list of all of the documents I have reviewed is attached to this Declaration as **Exhibit 2**.

10. In addition, I toured and inspected several NDCS facilities where restrictive housing units are located.[8] Specifically, on October 15, 2018, I toured and inspected the

[5] PLAINTIFF0019271-303.

[6] PLAINTIFF0018989-9270.

[7] PLAINTIFF0019420-51.

[8] Isolated prisoners in the NDCS can be designated as either "Immediate Segregation" ("IS"), which means their isolated confinement is initially reviewed within 15 days, but can last as long as 60 days, AR 210.01 III(D)(2), G, NDCS025025-26, or as "Longer Term Restrictive Housing" ("LTRH"), which is a classification allowing NDCS to place a prisoner in restrictive housing for a longer time period. NDCS025026-27. LTRH placement is reviewed every 90 days for the first year and then every 30 days thereafter. AR 210.01 IV(B)(4)(b), 6. NDCS025029-30. In addition, prisoners who are deemed seriously mentally ill and in need of "residential mental health treatment" but whom the NDCS believes require segregated housing can be placed in the "Secure Mental Health Unit" or ("SMHU") at the Lincoln Correctional Center. AR 210.01 VII(A). NDCS025031.

Tecumseh State Correctional Institution ("TSCI") and interviewed a sample of prisoners there; on October 16, 2018, I toured and inspected the Lincoln Correctional Center ("LCC") and interviewed a sample of prisoners there; on October 17, 2018, I inspected the Nebraska State Penitentiary ("NSP") and interviewed a sample of prisoners there; and, finally, on October 18, 2018, I inspected the Nebraska Correctional Center for Women ("NCCW") and interviewed a sample of prisoners there. In the course each of these facility visits, I conducted multiple kinds of interviews, including brief "cell-front" interviews with prisoners whom I encountered in the course of the inspections. In addition, I conducted separate confidential interviews with individual prisoners, all of whom are named plaintiffs in this case. At each of these facilities I was also able to question staff regarding operations, practices and policies. Finally, I spent some time at the end of each day reviewing both named plaintiff and non-named plaintiff prisoners' files (primarily the mental health portions of their records).

11. The face-to-face interviews with isolated NDCS prisoners housed in the various restrictive housing units that I toured included prisoners classified as Immediate Segregation ("IS") and Longer-Term Restrictive Housing ("LTRH"), and those in the Secure Mental Health Unit ("SMHU"). Some of those interviews were briefer and conducted cell front, and others were longer, confidential interviews conducted in a private setting at the prison.

12. By way of summary, it is my expert opinion that being housed in solitary or isolated confinement can produce a number of negative psychological effects and places prisoners at significant risk of serious psychological harm. I believe that these effects are now well understood and described in the scientific literature. Scientific knowledge of these effects derives from numerous empirical studies. The findings are "robust"—that is, they come from 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. With remarkably few exceptions, virtually every one of these studies has documented the pain and suffering that isolated prisoners endure and the risk of psychological harm that they confront.

13. In addition, the empirical conclusions are theoretically sound. That is, there are numerous widely accepted theoretical reasons to expect that long-term isolation, the absence of meaningful social interaction and activity, and the other severe deprivations that are common under conditions of isolated or solitary confinement would have harmful psychological consequences. Those conditions and experiences are known to produce adverse psychological effects in contexts other than prison and it makes perfect theoretical sense that they produce similar outcomes in correctional settings.

14. There are also sound theoretical reasons to expect that prisoners who suffer from SMI would have a more difficult time tolerating the painful experience of isolation or solitary confinement. This is in part because of the greater vulnerability of the mentally ill in general to stressful, traumatic conditions, and in part because 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.

15. It is also my opinion that the conditions of confinement in the NDCS isolation units that I observed in the facility tours and inspections I undertook and as described in the interviews of NDCS prison staff and prisoners that I conducted, and as reflected in the NDCS policies and practices I reviewed, are exactly the type of conditions that my own experience and study and decades of scientific research have found to place all prisoners at significant risk of serious harm, regardless of their pre-existing mental health status. As such, all NDCS prisoners are at significant risk of serious psychological harm as a result of the isolation conditions, practices, and policies to which they are subjected.

16. Despite the expressed intentions of the NDCS to significantly reform its isolated housing practices, the conditions that I observed were ones that subjected prisoners to severe forms of social isolation and other deprivations. Moreover—again, notwithstanding the expressed intentions of NDCS officials—the Nebraska prison system's use of "restrictive housing" is increasing, not decreasing. At the Nebraska State Penitentiary, for example, where, as I will describe later in this Declaration, conditions are especially problematic, the population of prisoners in restrictive housing has increased fully 43% between 2016 and 2018 (rising from an average daily population of 84.49 in 2016 to 120.29 in 2018).[9]

17. I should note that my opinions concerning the use, nature, and effects of isolated confinement in the NDCS are partial and preliminary. It is my understanding that additional information will be forthcoming during the course of this litigation. For example, to date I have been able to tour a total of four NDCS facilities, to interview only a limited number of staff and prisoners, and to review only a select number of prisoner files and other documents. Based on the tours and interviews I have conducted, and the documents and materials that I have reviewed, I am confident in the preliminary opinions that I have formulated about NDCS's isolation conditions, practices, and policies. However, I anticipate that these opinions will be further developed and supplemented as more information becomes available.

III. The Adverse Psychological Effects of Isolation

18. "Solitary confinement" and "restrictive housing" are terms of art in correctional practice and scholarship, but they mean essentially the same thing. For perhaps obvious reasons, total and absolute solitary confinement—literally complete isolation from any form of human

[9] See NDCS Restrictive Housing Annual Report at 5. PLAINTIFF0019276. The use of restrictive housing at NSP and elsewhere has increased despite the fact that the prison population in NDCS custody has remained constant over the past few years. See OIG Report at 38. PLAINTIFF0019027.

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. In Nebraska, the legislature has defined "restrictive housing" as "conditions of confinement that provide limited contact with other offenders, strictly controlled movement while out of cell, and out-of-cell time of less than twenty-four hours per week" NEB. REV. ST. § 83-170(13). This definition is consistent with the type of conditions typically considered "solitary confinement" in the literature and jurisdictions across the country.

19. Although research indicates that solitary confinement fails to accomplish its alleged goal, it is presumably designed to limit and control violence by keeping prisoners isolated from one another. Unfortunately, it also subjects prisoners to especially harsh and deprived conditions of isolated confinement that place prisoners at a significant risk of serious psychological harm. As a general matter, psychologists know from numerous studies conducted in settings outside prison that social isolation, social exclusion, and loneliness in general are potentially very harmful and can cause irreparable damage to a person's overall psychological and physical functioning.[10] Not only is there no reason to believe that these conditions would be less harmful in prison but also, because of the harsh, forceful ways they are imposed in correctional settings and the other deprivations that typically accompany them, they are likely even more damaging.

20. In addition to the extensive research conducted outside of prison settings, there is a large and growing direct literature on the many ways that solitary confinement per se can very seriously damage the overall mental health of prisoners. The long-term absence of meaningful

[10] For example, see: Graham Thornicroft, Social Deprivation and Rates of Treated Mental Disorder: Developing Statistical Models to Predict Psychiatric Service Utilisation, British Journal of Psychiatry, 158, 475-484 (1991).

human contact and social interaction, the enforced idleness and inactivity, and the oppressive security and surveillance procedures (and the weapons, hardware, and other paraphernalia that go along with them) all combine to create starkly deprived conditions of confinement. These conditions predictably impair the psychological functioning of many prisoners who are subjected to them.[11] The measured effects are cognitive, emotional, and behavioral in nature and, for some prisoners, the resulting impairments can be permanent and life-threatening.

21. In the admitted absence of a single "perfect" study of the phenomenon,[12] the substantial body of published literature clearly documents the distinctive patterns of

[11] For example, see: Bruce Arrigo & J. Bullock, The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and What Should Change, International Journal of Offender Therapy and Comparative Criminology, 52, 622-640 (2008); Kristin Cloyes, David Lovell, David Allen & Lorna Rhodes, Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, Criminal Justice and Behavior, 33, 760-781 (2006); Stuart Grassian, Psychiatric Effects of Solitary Confinement, Washington University Journal of Law & Policy, 22, 325-383 (2006); Craig Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. Crime & Delinquency, 49, 124-156 (2003); Craig Haney, Restricting the Use of Solitary Confinement, Annual Review of Criminology, 1, 285-310 (2018); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: The Psychological Consequences of Solitary and Supermax Confinement*, New York Review of Law & Social Change, 23, 477-570 (1997); and Peter Smith, The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature, in Michael Tonry (Ed.), Crime and Justice (pp. 441-528). Volume 34. Chicago: University of Chicago Press (2006). There are a few outlier studies that purport to find few if any negative effects. For a detailed discussion of the serious methodological flaws that plague these studies, see: Craig Haney, The Psychological Effects of Solitary Confinement: A Systematic Critique, Crime and Justice, 47, 365-416 (2018).

[12] The "perfect" study of the effects of solitary confinement is relatively straightforward to design but impossible to implement. It would include: dividing a representative sample of prisoners (who had never been in solitary confinement) into two groups by randomly assigning half to either a treatment condition (a significant period in solitary confinement) or a control condition (the same length of time residing in a typical prison housing unit), and conducting longitudinal assessments of both groups (i.e., before, during, and after their experiences), by impartial researchers skilled at gaining the trust of prisoners (including ones perceived by the prisoner-participants as having absolutely no connection to the prison administration), in a fashion that minimized or eliminated "practice effects" (that come about as a result of repeated testing). Unfortunately, the realities of prison life and the practical and ethical challenges of conducting research in prisons render such a study impossible to ever conduct. Moreover, any prison system that allowed truly independent, experienced researchers to perform even a

psychological harm that can and do occur when persons are placed in solitary confinement. 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 span a period of over many decades, and were conducted in locations across several continents by researchers with different professional expertise, ranging from psychiatrists to sociologists and architects.[13]

22. 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.[14] 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."[15]

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reasonable approximation of such a study would be, almost by definition, so atypical as to call the generalizability of the results into question. Keep in mind also that the assessment process itself—depending on who carried it out, how often it was done, and in what manner—might well provide the solitary confinement participants with more meaningful social contact than they are currently afforded in a number of such units with which I am familiar, thereby significantly changing (and improving) the conditions of their confinement.

[13] For example, see the studies referenced in the review articles listed in footnote 11 above.

[14] Here, too, discussions of and citations to these studies appear in the review articles listed in footnote 11 above

[15] Bruno Cormier & Paul Williams, Excessive Deprivation of Liberty, Canadian Psychiatric Association Journal, 11, 470-484 (1966), at p. 484. 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, Journal of Abnormal Psychology, 79, 54-59 (1972); George Scott & Paul Gendreau, Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison, Canadian Psychiatric Association Journal, 12, 337-341 (1969); Richard H. Walters, John E. Callagan & Albert F. Newman, Effect of Solitary Confinement on Prisoners, American Journal of Psychiatry, 119, 771-773 (1963).

23. A decade later, Professor Hans Toch's large-scale psychological study of prisoners "in crisis" in New York State correctional facilities included important observations about the effects of isolation.[16] 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.[17] 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."[18]

24. 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 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.[19]

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

[17] Id. at 54.

[18] Ibid.

[19] In addition to the numerous studies cited in the articles referenced *supra* at note 11, there is a significant international literature on the adverse effects of solitary confinement. For example, *see* Henri Barte, L'Isolement Carceral, Perspectives Psychiatriques, 28, 252 (1989). Barte

25. In addition, there are correlational studies of the relationship between housing type and various kinds of incident reports in prison. They show that self-mutilation and suicide are more prevalent in isolated, punitive housing units such as administrative segregation and

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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), Psychologie - Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen, 42, 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), Psychologie - Schweizerische Zeitschrift fur Psychologie und ihre Anwendungen, 42, 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), Psychiatria Clinica, 16, 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 & 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 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, Journal of Nervous & Mental Disease, 181, 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.

security housing 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.[20] 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 suicide."[21] 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.[22]

26. The painfulness and damaging potential of extreme forms of solitary confinement is underscored by its use 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

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

[21] Ibid. 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, Psychiatric Quarterly, 60, 7 (1989); Alison Liebling, Vulnerability and Prison Suicide, British Journal of Criminology, 36, 173-187 (1995); and Alison Liebling, Prison Suicide and Prisoner Coping, Crime and Justice, 26, 283-359 (1999).

[22] For example, see Howard Bidna, Effects of Increased Security on Prison Violence, Journal of Criminal Justice, 3, 33-46 (1975); K. Anthony Edwards, Some Characteristics of Prisoners Transferred from Prison to a State Mental Hospital, Behavioral Sciences and the Law, 6, 131-137 (1988); Elmer H. Johnson, Felon Self-Mutilation: Correlate of Stress in Prison, in Bruce L. Danto (Ed.) Jail House Blues. Michigan: Epic Publications (1973); Anne Jones, Self-Mutilation in Prison: A Comparison of Mutilators and Nonmutilators, Criminal Justice and Behavior, 13, 286-296 (1986); Peter Kratcoski, The Implications of Research Explaining Prison Violence and Disruption, Federal Probation, 52, 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, Journal of Interpersonal Violence, 1, 213-237 (1986); and Pamela Steinke, Using Situational Factors to Predict Types of Prison Violence, 17 Journal of Offender Rehabilitation, 17, 119-132 (1991).

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.[23]

27. The prevalence of psychological symptoms (that is, the extent to which prisoners who are placed in these units suffer from these and related symptoms) is often very high. For example, in a study that I conducted of a representative sample of one hundred prisoners who were housed in the Security Housing Unit at Pelican Bay Prison in California, 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.[24] Many of the symptoms were reported by two-thirds or more of the prisoners assessed in this isolation housing unit, and some were suffered by nearly everyone. Well over half of the Pelican Bay isolated prisoners in this study reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that is commonly associated with hypertension.

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[23] 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 Other Cruel, Inhuman or Degrading Treatment or Punishment, 27 Boston College International & Comparative Law Review, 27, 275 (1994); Tim Shallice, Solitary Confinement—A Torture Revived? New Scientist, November 28, 1974; F.E. Somnier & I.K. Genefke, Psychotherapy for Victims of Torture, British Journal of Psychiatry, 149, 323-329 (1986); and Shaun R. Whittaker, Counseling Torture Victims, The Counseling Psychologist, 16, 272-278 (1988).

[24] See discussions of these data in Craig Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement (2003), and more recent data collected at the same facility, showing much the same pattern of results, Craig Haney, Restricting the Use of Solitary Confinement (2018), cited in footnote 11 above.

28. With respect to a separate set of symptoms—those that have been identified in the literature as direct psychopathological effects of isolation—I also found that almost all of the prisoners whom I evaluated 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.

29. Although these specific symptoms of psychological stress and the psychopathological reactions to isolation are numerous and well-documented, and certainly provide one index of the magnitude of the risk of harm this kind of experience presents, they do not encompass all of the psychological pain and dysfunction that such confinement can incur, the magnitude of the negative changes it may bring about, or even the full range of the risk of harm it represents. Among other things, such extreme deprivation of social contact can undermine an individual's social identity, destabilize his or her sense of self, and ultimately destroy one's ability to function normally in free society.

30. Depriving people of contact with others for long periods of time is psychologically harmful and potentially destabilizing for another, related set of reasons. The importance of "affiliation"—the opportunity to have meaningful contact with others—in reducing anxiety in the face of uncertain or fear-arousing stimuli is long-established in social

psychological literature.[25] In addition, one of the ways that people determine the appropriateness of their feelings—indeed, how we establish the very nature and tenor of our emotions—is through contact with others.[26]

31. Solitary confinement is a socially pathological environment that forces long-term inhabitants to develop their own socially pathological adaptations—ones premised on the absence of meaningful contact with people—in order to function and survive. As a result, prisoners gradually change their patterns of thinking, acting and feeling to cope with their largely asocial world and the impossibility of relying on social support or the routine feedback that comes from normal contact with others. Clearly, then, these adaptations represent "social pathologies" brought about by the socially pathological environment of isolation. However, although they are functional and even necessary under these circumstances, they can become especially painful and disabling if taken to extremes, or if and when they are internalized so deeply that they persist long after time in isolation has ended.

32. For example, some prisoners cope with the asociality of their daily existence by paradoxically creating even more. That is, they socially withdraw further from the world around them, receding even more deeply into themselves than the sheer physical isolation of solitary

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[25] 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, Journal of Abnormal Social Psychology, 62, 356-363 (1961); Philip Zimbardo & Robert Formica, Emotional Comparison and Self-Esteem as Determinants of Affiliation, Journal of Personality, 31, 141-162 (1963).

[26] For example, see: A. Fischer, A. Manstead, & R. Zaalberg, Social Influences on the Emotion Process, in M. Hewstone & W. Stroebe (Eds.), European Review of Social Psychology (pp. 171-202). Volume 14. 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, Psychological Review, 69, 379-399 (1962); L. Tiedens & C. Leach (Eds.), The Social Life of Emotions. New York: Cambridge University Press (2004); and S. Truax, Determinants of Emotion Attributions: A Unifying View, Motivation and Emotion, 8, 33-54 (1984).

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.

33. Although social deprivation is at the core of solitary confinement, and what seemingly accounts for its most intense psychological pain and the greatest risk of harm, prison isolation units also deprive prisoners of more than social contact. Thus, there are characteristically high levels of repressive control, enforced idleness, reduced positive environmental stimulation, and physical and material deprivations that also lead to psychological distress and can create even more lasting negative consequences. Indeed, most of the things that we know are beneficial to prisoners—such as increased participation in institutional programming, visits with persons from outside the prison, physical exercise, and so on[27]—are either functionally denied or greatly restricted in solitary confinement units. In addition to the social pathologies that are created by the deprivation of normal, meaningful social contact, these other stressors also can produce additional negative psychological effects.

34. In addition, of course, people require a certain level of mental and physical activity in order to remain healthy. The near total lack of movement and opportunity for exercise experienced by most prisoners in isolation unquestionably impacts their mental health. Simply put, human beings need movement and exercise to maintain healthy mental functioning—without the possibility for such normal and necessary human activity, prisoners in isolation suffer a risk of serious mental harm.

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

35. Apart from the profound social, psychological, and physical deprivations that solitary confinement imposes, prisoners housed in these units experience prolonged periods of monotony and idleness. Many of them experience a form of sensory deprivation—there is an unvarying sameness to the physical stimuli that surround them, they exist within the same limited spaces and are subjected to the same repetitive routines, and there is little or no external variation to the experiences they are permitted to have or can create for themselves. This loss of perceptual and cognitive or mental stimulation may result in the atrophy of important related skills and capacities.[28]

36. I hasten to add that not every isolated prisoner experiences all or even most of the range of adverse reactions that I have described above. But the nature and magnitude of the negative psychological consequences themselves underscore the stressfulness of this kind of confinement, the lengths to which prisoners must go to adapt and adjust to it, and the risk of harm that is created by isolation and its broad range of severe stressors and deprivations. The devastating effects of the conditions typically found in isolation units are repeatedly played out in the characteristically high numbers of suicide deaths and incidents of self-harm and self-mutilation. Given the years of sustained research on solitary confinement and the observable outcomes produced by this form of incarceration across time and locality, there can be no doubt that the negative psychological impact of confinement in these environments is often severe and, for some prisoners, sets in motion a set of cognitive, emotional, and behavioral changes that are long-lasting. Indeed, they can persist beyond the time that prisoners are housed in isolation and, for some, will prove irreversible.

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[28] See the articles cited in the reviews referenced in footnote 11. In addition, see: Stanley Brodsky & Forrest Scogin, Inmates in Protective Custody: First Data on Emotional Effects, *Forensic Reports, 1(4)*: 267-289 (1988)

IV. The Exacerbating Effects of Isolation on Mental Illness

37. Although isolated confinement creates obvious risks of harm for all, most experts acknowledge that the adverse psychological effects of isolated or solitary confinement 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. Unusually resilient prisoners may be able to withstand even harsh forms of solitary confinement with few or minor adverse effects. Conversely, some prisoners are especially vulnerable to the psychological pain and pressure of solitary confinement. Mentally ill prisoners are particularly at risk in these environments and have been precluded from them precisely because of this.[29] There are several reasons that explain their heightened vulnerability.

38. For one, as I have noted, solitary confinement or isolation is a significantly more stressful and psychologically painful form of prison confinement for most prisoners. 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 benign and socially supportive atmosphere that mental health clinicians seek to create within therapeutic environments. Not surprisingly, mentally ill prisoners generally deteriorate and decompensate when they are placed in isolation units.

39. Some of the exacerbation of mental illness that occurs in isolated confinement comes about as a result of the critically important role that social contact and social interaction play in maintaining psychological equilibrium. The esteemed psychiatrist Harry Stack Sullivan

[29] For example, see: Madrid v. Gomez, 889 F.Supp. 1146 (N.D. Cal. 1995); Ruiz v. Johnson, 37 F.Supp.2d 855 (S.D. Tex. 1999); Jones'El v. Berge, 164 F. Supp.2d 1096 (W.D. Wisc. 2001); and Ind. Protection and Advocacy Comm'n v. Comm'r, Ind. Dep't of Corr., No. 1:08-CV-01317-TWP, 2012 WL 6738517 (S.D. Ind. 2012).

once summarized the clinical importance 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."[30] Social contact and social interaction are essential components in the creation and maintenance of normal social identity and social reality.

40. For this reason, one of the most fundamental ways that solitary confinement psychologically destabilizes prisoners is by undermining their sense of self or social identity and eroding their 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.[31]

In extreme cases, a related pattern emerges: isolated confinement becomes so painful, so bizarre, and so impossible to make sense of that some prisoners create their own reality—they live in a world of fantasy instead of the intolerable one that surrounds them.

41. Finally, many of the direct negative psychological effects of isolation are themselves very similar if not identical to certain symptoms of mental illness. Even though these specific effects are typically thought to be less chronic or persistent when produced by the

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

[31] Compare, also, Margaret Cooke & Jeffrey Goldstein, Social Isolation and Violent Behavior, Forensic Reports, 2, 287-294 (1989), at p. 288.

prisoner's conditions of confinement than those that derive from a diagnosable mental illness, when they occur in combination they are likely to exacerbate not only the outward manifestation of the symptoms but also the internal experience of the disorder. For example, many studies have documented the degree to which isolated confinement contributes to feelings of lethargy, hopelessness, and depressed mood. For clinically depressed prisoners, these 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 in isolation would be expected to amplify the 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.

42. As a result of the special vulnerability of mentally ill prisoners to the psychological effects of solitary confinement, corrections officials and courts that have considered the issue have prohibited them from being placed in such units.[32] In addition, mental health staff in most prison systems with which I am familiar are charged with the responsibility not only of screening prisoners in advance of their possibly being placed in isolation (so that the mentally ill can be excluded) but also of monitoring prisoners who are currently housed in solitary confinement for signs of emerging mental illness (so that they, too, can be removed). For example, one court that was presented with systematic evidence of the psychological risk of harm that solitary confinement entailed concluded that the seriously mentally ill must be

[32] See the cases cited in footnote 29.

excluded from such environments. Thus, the court noted that those prisoners for whom the psychological risks 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]."[33] The court elaborated on this conclusion by noting that those who should be excluded from isolated confinement included:

> [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."[34]

43. The accumulated weight of the scientific evidence that I have cited to and summarized above demonstrates the negative psychological effects of isolated confinement—what happens to people who are deprived of normal social contact for extended periods of time. This evidence underscores the dangers isolation creates for human beings in the form of mental pain and suffering and increased tendencies towards self-harm and suicide. This evidence further underscores the psychological importance of meaningful social contact and interaction, and in essence establishes these things as identifiable human needs. Over the long-term, they 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.

V. The Use of Solitary Confinement in the Nebraska Department of Correctional Services

44. As I noted above, the adverse psychological effects of solitary confinement are thought to vary as a function of the specific nature and duration of the isolated conditions to

[33] Madrid v. Gomez, 889 F.Supp. 1146, 1265 (N.D. Cal. 1995) (citation omitted).

[34] Ibid.

which prisoners are exposed. In this regard, there are better and worse solitary confinement units, including some that seek to ameliorate the harsh conditions that they impose and try minimize the harm that they inflict on prisoners. And, as I also noted, there are more and less resilient prisoners, including some who seem able to withstand the painfulness of these environments and to recover from the experience with few if any lasting effects. But neither of these facts undercuts the overall consensus that has emerged on the harmful effects of long-term isolation and the serious risk of such harm that this form of confinement poses for all prisoners who are subjected to it.

45. As I indicated in my initial summary of my expert opinions, my evaluation of the exact nature and the effects of the conditions of isolation in the Nebraska Department of Correctional Services is not complete. I look forward to conducting additional onsite inspections of conditions of confinement at specific facilities, interviewing a larger number of prisoners who are confined in them, and reviewing additional, discovery materials.

46. However, there are several things that I can say at this stage of my analysis. The first is that the use of solitary confinement or "restrictive housing" in any prison system is affected by the larger context in which it occurs. Nebraska is no exception. According to the 2017/2018 OIG report, NDCS is severely overcrowded, operating at 157% of design capacity.[35] As problematic and dangerous to the health and well-being of both staff and inmates this overall level of overcrowding is, the system-wide average masks even higher and more problematic levels at certain individual facilities. For example, the state's major maximum-security prison,

[35] OIG Annual Report at 27. PLAINTIFF0019016. A recent review of the NDCS website indicates that the overcrowding problem is actually growing. As of February 11, 2019, NDCS reports that the average daily population is 161% of design capacity. See Nebraska Department of Correctional Services, Average Daily Population, available at https://corrections.nebraska.gov/public-information/ndcs-research-division.

the Nebraska State Penitentiary, is operating at an astonishing 184% of capacity, nearly twice the number of prisoners for which it was designed.[36] In addition, there are equal if not greater staffing shortages. Thus, the OIG noted that "two years after the 2016 OIG report declared that NDCS was facing a staffing crisis, the situation has not resolved itself."[37]

47. Given the high levels of persistent overcrowding in NDCS, it is perhaps not surprising that the overall use of restrictive housing has continued to increase over the last four years. In any event, this steady increase is both disappointing and problematic. It is disappointing because Director Frakes and NDCS officials have explicitly committed the Department to achieve reductions in the use of restrictive housing, as evidenced in part by their partnership with the Vera Institute of Justice Safe Alternatives to Segregation initiative. Yet not only has this goal not been achieved but the opposite has occurred: there have been steady increases in the number of prisoners placed in restrictive housing since November 2014, and the number of prisoners kept there for over 180 days has more than doubled over the last two years, from 62 prisoners in August 2016 to 158 in the summer of 2018.[38]

48. The increase rather than decrease in the number of prisoners in restrictive housing appears to stem in part from the fact that the mechanisms or processes designed to reduce the use of solitary confinement are not operating as planned. For example, The Challenge Program ("TCP") is supposedly a way out of restrictive housing, but it is far from an expeditious route to general population. As the OIG noted, after Phase I (which is served in restrictive housing), "Phase II and Phase III participants may leave restrictive housing, [but] they still end up

[36] Id. at 39. PLAINTIFF0019028.

[37] Id. at 27. PLAINTIFF0019016.

[38] Id. at 56-57. PLAINTIFF0019045-46.

spending at least 38 weeks in a setting that could be called 'Restrictive Housing Lite.'"[39] This may account for the fact that "NDCS is having a difficult time convincing those inmates selected for the program to complete it."[40] The lack of prisoner interest in or willingness to participate has resulted in many unused cells (at the time of the OIG report, 82 empty beds) in an otherwise extremely overcrowded prison system.[41]

49. Although they may differ in the duration of the isolated confinement and the purpose for which someone is housed there, all of the variations of what is called "restrictive housing" in the Nebraska prison system—including Immediate Segregation ("IS"), Longer-Term Restrictive Housing ("LTRH"), The Challenge Program ("TCP"), and the Secure Mental Health Unit ("SMHU")—are similar in a number of basic, problematic respects.[42] They all deprive prisoners of meaningful social contact and impose other extremely harsh restrictions, varying primarily only in terms of the length of time to which prisoners are subjected to them.[43] Moreover, it should be noted that prisoners classified as IS and LTRH are not separated into

[39] Id. at 65. PLAINTIFF0019054.

[40] Id. at 54. PLAINTIFF0019053.

[41] Id.

[42] For example, see NDCS AR 210.01, Attachment H. NDCS025054.

[43] According to NDCS Restrictive Housing Reports the average stay in restrictive housing for fiscal year 2017 was 74 days. As of July 1, 2017, 74 individuals had spent over 180 days in restrictive housing. See NDCS Restrictive Housing Report 2017. PLAINTIFF0016110. For fiscal year 2018, the average stay in restrictive housing was 48.39 days and 3% of placements were for over 1 year. See NDCS Restrictive Housing Report 2018. PLAINTIFF0019281. These data appear to reflect a reduction in the average length of stay in restrictive housing. While reducing time in isolation is a positive step, it is insufficient to ameliorate the myriad risks of harm discussed in this Declaration. The severity of the conditions, the practice of isolating vulnerable prisoners, and the still-extended duration of isolation continue to pose serious risks of harm for the prisoners subjected to restrictive housing in NDCS.

different units; they are all housed in the same restrictive housing units regardless of classification.

50. There are five institutions that contain restrictive housing units: Lincoln Correctional Center (which also houses the SMHU, a restrictive housing unit governed by a different regulation as explained below), Nebraska State Penitentiary, Nebraska Correctional Center for Women, Nebraska Correctional Youth Facility, and Tecumseh State Correctional Institution. All are governed by Administrative Regulation ("AR") 210.01.[44] LCC, NCCW, and NCYF all declined to issue their own policies or operational memoranda implementing this regulation, instead simply adopting the AR wholesale.[45] TSCI issued a short operational memorandum ("OM")—9 pages to AR 210.01's 25—which acknowledges that AR 210.01 "details both policy and specific procedures as they relate to the subject of conditions of restrictive housing unit confinement."[46] NSP issued its own OM, which includes institution-specific procedures but also repeats much of the language of the Administrative Regulation.[47] LCC also contains the SMHU, which is subject to its own set of policies and procedures. However, prisoners housed in the SMHU are only provided a minimum of ten hours per week out of cell, including showers and exercise, and are subjected to substantially the same conditions of confinement as other prisoners housed in restrictive housing.[48] Notably, neither AR 210.01 nor LCC OM 115.12.02 IV (governing the SMHU) require the exclusion of people with SMI from restrictive housing. Yet the conditions to which both policies refer clearly constitute

[44] See NDCS025021.

[45] See NDCS039386; PLAINTIFF0010695; and PLAINTIFF0010814, respectively.

[46] NDCS051534.

[47] PLAINTIFF0010943-11013.

[48] See LCC OM 115.12.02 IV, NDCS038993-97.

restrictive housing, precisely the kind of confinement that is especially damaging for individuals suffering from serious mental illness.

51. The conditions of confinement in all of the restrictive housing units I toured are severe. For instance, the physical plant of each of the housing units is very similar in construction and in the level of social isolation and environmental deprivation it inflicts on prisoners housed there.[49] The cells are small and inhospitable[50] and, with only a few exceptions, the recreation areas that I saw were fenced-in cages with little or no exercise equipment inside them.[51] These severe restricted housing conditions exist even in the women's facility, NCCW,[52] a prison whose mainline housing units were notable for their college-like atmosphere, and in the LCC Secure Mental Health Unit ("SMHU"), which supposedly operates as a therapeutic treatment unit, but has small cells and barren recreation pens, shared with another adjoining regular restrictive housing unit, for prisoners to exercise in.[53] One would be hard-pressed to distinguish the living conditions in either of these two places from the harsh, deprived, and inhospitable conditions that exist in the other NDCS solitary confinement units.[54]

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[49] See generally Exhibit 3, Photographs of Restrictive Housing Units at LCC, NCCW, TSCI, and NSP.

[50] See Exhibit 3, NDCS084413 (TSCI); NDCS084278 (LCC); NDCS150041 and NDCS150079 (NCCW); NDCS084312 and NDCS084340 (NSP).

[51] See Exhibit 3, NDCS084300 and NDCS084335 (NSP); NDCS084256 and NDCS084262 (LCC); NDCS150027, NDCS150044, and NDCS150045 (NCCW); NDCS084398 and NDCS084417 (TSCI).

[52] See Exhibit 3, NDCS150027, NDCS150041, NDCS150044, NDCS150045, NDCS150059, and NDCS150079.

[53] See Exhibit 3, NDCS084252, NDCS084262, and NDCS084256.

[54] See Exhibit 3, NDCS084385 (TSCI); NDCS084339 (NSP); NDCS150059 and NDCS150027 (NCCW); NDCS084252 and NDCS084266 (LCC).

52. In addition, prisoners in these units are afforded extremely limited out-of-cell time. Under Section IX of AR 210.01 which governs general conditions of confinement in restrictive housing units across the system, for example, policy mandates that only 1 hour of yard/exercise must be permitted 5 days a week, as well as 3 opportunities per week to shave and shower.[55] However, shower and exercise may be "curtailed" to as few as 3 times per week (and fewer than that "in emergencies").[56] Although prisoners housed in restrictive housing for longer than 30 days are supposed to "have access to programs and services[,]" the access is largely limited to whatever can be provided in-cell.[57] In reality, even in the SMHU which allegedly houses individuals with mental illness so acute that they require a residential level of care,[58] access to programming or activity of any kind appears extremely limited both in practice and under the operative policies which do not mandate out-of-cell time and socialization opportunities discernibly different from general restrictive housing.[59]

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[55] See AR 210.01 XI(A), NDCS025035 (as explained above, LCC, NCCW, and NCYF adopted AR 210.01 in its entirety without issuing their own implementing OMs); NSP OM 210.001.101 IV(Q)(1), PLAINTIFF0010965; TSCI OM 210.01.01 II(E), (K), NDCS051536-37. This limitation also applies to prisoners housed in the SMHU. LCC OM 115.12.02 IV(B)(5), (14). NDCS038994.

[56] AR 210.01 XI(F), NDCS025037; NSP OM 210.001.101 IV(Q)(6), PLAINTIFF0010968

[57] AR 210.01 XI(B), NDCS025035; NSP OM 210.001.101 V(Q)(2), PLAINTIFF0010965; TSCI OM 210.01.01 II(M), NDCS051537; LCC OM 115.12.02 IV(B)(15) (SMHU), NDCS038994.

[58] AR 210.01 VII(A), NDCS025031.

[59] For example, under the OM for the SMHU, prisoners who reach level 3 or 4 "may be allowed to participate in dayroom leisure activities with or without peers up to 2 hours per day". This is completely discretionary and level 1 or 2 prisoners don't even have the possibility of such out-of-cell time. LCC OM 115.12.02 at 6 (NDCS038997). During my tour of SMHU I saw no evidence that any prisoners on the unit were allowed "dayroom" time and none of the prisoners I spoke with indicated that they were regularly allowed out of their cell in the dayroom for two hours a day --- or at all.

53. Visitation is limited for prisoners in all restrictive housing units; even when they are permitted contact visits, they are almost always in full restraints.[60] Prisoners in restrictive housing are afforded very limited property, and given limited access to TVs or radios.[61] During my on-site interviews I encountered many prisoners who reported spending extremely long periods of time—months and years—in such conditions.[62]

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[60] See AR 210.01 XI(A)(10) (requiring only that all prisoners housed in restrictive housing have "opportunities to visit"), NDCS025035; LCC OM 115.12.02 at 5 (SMHU) (allowing prisoners to have contact visits in full restraints, with non-restrained visits reserved for prisoners on level 4), NDCS038996; NSP OM 210.001.101(IV)(Q)(4) (limiting non-contact visitation to one hour according to a schedule authorized by the Warden), PLAINTIFF0010965; NCCW OM 210.01.4.01 (adopting AR 210.01, including its visitation requirement) (according to staff, prisoners housed in NCCW restrictive housing custody are permitted contact visitation only in full restraints), PLAINTIFF0010695; LCC OM 210.01.01 (adopting AR 210.01, including its visitation requirement) (according to staff, prisoners housed in LCC restrictive housing custody are permitted contact visitation only in full restraints), NDCS039386; NCYF OM 210.1.1 (adopting AR 210.01, including its visitation requirement), PLAINTIFF0010814; TSCI OM 210.01.01 II(G) (permitting prisoners in restrictive housing units to visit only over Closed Circuit Television), NDCS051537.

[61] See AR 210.01 XI(D)(1) (permitting prisoners in restrictive housing to have earbuds, one television, and "hygiene/stationary [sic] items" subject to their behavior and programming plans) and XI(D)(2) (listing limited property for prisoners on IS status), NDCS025035-36; LCC OM 115.12.02 at 4, 6 (SMHU) (permitting prisoners to have "authorized personal items" and personal radio and television sets with headphones), NDCS038995, NDCS038997; NSP OM 210.001.101 IVQ(4)(a), (b)(1) (permitting restrictive housing prisoners to possess earbuds, one television, and "hygiene/stationary [sic] items" subject to their behavior and programming plans; listing the same limited property allowed to prisoners on IS status as in AR 210.01), PLAINTIFF0010965-66; NCCW OM 210.01.4.01 (permitting prisoners on IS status to have the same property as listed in AR 210.01 and those on LTRH status to have earbuds, a headphone extension cord, and up to five books in their cells as "incentives"; a policy directive disallowed wristwatches as personal property in restrictive housing), PLAINTIFF0010696-97; LCC OM 210.01.01 (adopting AR 210.01, including the personal property restrictions), NDCS039386; NCYF OM 210.1.1 (adopting AR 210.01, including the personal property restrictions), PLAINTIFF0010814; TSCI OM 210.01.01 II(D), VI(F)(1) (allowing "personal items" as authorized in post orders; listing limited property allowed for prisoners on IS status), NDCS051536, NDCS051540-41.

[62] See NDCS 2018 Restrictive Housing Annual Report at 10 (estimating that 30 percent of the 1,856 prisoners in restrictive housing had been there for over a month, including 3 percent—approximately 56 people—who had been in restrictive housing for over one year). PLAINTIFF0019281.

54. In the course of my visits to various NDCS facilities, I conducted cell-front interviews with several dozen prisoners and also interviewed a number of prisoners on an individual, confidential basis. The prisoners I interviewed confidentially are named plaintiffs in this action. Their descriptions of their experiences in restrictive housing in NDCS and the harms they have suffered there were remarkably consistent with the information that I obtained from the dozens of random cell-front interviews that I also conducted during the tour and with the information contained in the documents I reviewed. Prisoner after prisoner voiced a host of very serious, very similar concerns. Many of them described the painfulness of their confinement and the psychological harm to which they were being subjected. Their complaints and concerns appeared to me to be genuine and heartfelt, justified by the severity of the conditions and levels of deprivation to which they were being subjected, and were entirely consistent with those I have documented from prisoners in harsh solitary confinement units elsewhere in the country.

55. Virtually all of the prisoners in restrictive housing in NDCS with whom I spoke complained about the severe levels of idleness to which they were subjected. Many prisoners with whom I spoke told me they were on the prison's mental health caseload, were taking psychotropic medications (typically as treatment for very serious forms of mental illness, including schizophrenia, psychosis, bi-polar disorder, major depression, and PTSD).[63] These prisoners complained about severity of the isolated conditions under which they were living, the constant stress, and the lack of consistent, meaningful mental health treatment. A number of them told me about (and showed evidence of) past incidents of self-harm as well as reporting past suicide attempts. Yet they remained confined in harsh and deprived solitary confinement

[63] Based on 2017 data, the Office of Inspector General reported that more than a quarter (28%) of prisoners in restrictive housing suffer from mental illness. OIG Annual Report at 67. PLAINTIFF0019056. My impression, from the units I toured and the prisoners I interviewed, was that the percentage was much higher.

units. These prisoners were virtually unanimous in wanting more mental health treatment but, as they told me, despite their requests, they were not getting it. Prisoners also consistently complained about the lengthy and indefinite nature of their confinement—"I don't know how I'll get out" was a common refrain—and some complained about the fact that overcrowding in the system at large meant that programs they needed for parole eligibility were unavailable to them, which kept them stuck in the system.

56. Even the prisoners in The Challenge Program ("TCP"), which is supposed to be carefully structured and program-rich, consistently complained about having nothing to do, getting little or no mental health care (except for medications), and criticized the quality of minimal programming they did get as "pointless" or "meaningless." The OIG's description of TCP as "Restrictive Housing Lite" was borne out both by my own observations, the description of the program by prison personnel, and the comments of the prisoners themselves. As the officer responsible for therapeutic programming explained, prisoners in "group" sessions "are secured with leg irons and are locked down" in the course of their treatment. Moreover, it is important to note that prisoners who come into the first phase of the TCP program must initially spend time under severe restrictive housing conditions until they reach higher levels in the program and only then graduate to "Restrictive Housing Lite."

57. Similarly, based on my onsite inspection, interviews with prisoners, and policy review, the Secure Mental Health Unit ("SMHU") at the Lincoln Correctional Center appears to be run just like a restrictive housing or solitary confinement unit. There was very little movement in the unit and prisoners seemed mostly confined to their cells. The outdoor exercise areas, which are the same as those used by prisoners in the regular restrictive housing unit, were small,

fenced-in rec cages with concrete floors that hardly resembled an outdoor "yard."[64] In SMHU there was no evidence of adequate, out-of-cell clinical treatment, active group programming or sufficient non-clinical out-of-cell time for the population with SMI. Instead, the conditions were the same or very nearly the same as those for prisoners in the non-SMI restrictive housing units.[65]

58. My review of the prisoner files,[66] including those of named plaintiff and non-named plaintiff prisoners, added even greater weight to the prisoners' complaints, documenting the plights of prisoners with long histories of very serious mental illnesses. (A list of all of the prisoner records reviewed is included in **Exhibit 2**.) The files included recorded multiple instances of suicidality or extreme acting out by prisoners who were nonetheless kept in—or routinely returned to—harsh solitary confinement units, where they were once again placed at an especially significant risk of grave harm. In a number of cases, the prisoners' repeated pleas to mental health staff to the effect that they were being harmed by—and decompensating in response to—the severe of the conditions to which they were subjected were duly noted, but to no avail.

59. For example, Patient WW has spent the vast majority of his many-year prison sentence in restrictive housing[67] despite diagnosis of multiple serious mental illnesses including Bipolar Disorder and Schizoaffective Disorder.[68] Patient WW has engaged in self-harm on a

[64] See **Exhibit 3**, NDCS084262, NDCS084256.

[65] See generally LCC OM 115.12.02 (describing conditions of confinement in the SMHU). NDCS038992-9002.

[66] See **Exhibit 2** for a list of all prisoner files reviewed.

[67] NDCS 100038-40.

[68] NDCS 100041.

number of occasions, in the most recent case so severely that he required outside hospitalization.[69] Patient WW himself has expressed that restrictive housing exacerbates his mental illness.[70]

60. Patient EEE entered NDCS custody as a minor without any significant mental health diagnoses.[71] After a single violent incident, he was transferred to a restrictive housing unit in an adult facility and shortly thereafter decompensated rapidly, including playing with and eating his own feces.[72] He was then diagnosed with a variety of serious mental illnesses, including Major Depressive Disorder and Paranoid Schizophrenia.[73] He remains in a restrictive housing unit other than the SMHU, despite his significant diagnoses and his stated belief that his long time in restrictive housing has caused his mental illness.[74]

61. Plaintiff Dylan Cardeilhac likewise entered NDCS custody as a minor and has spent most if not nearly all of his sentence in restrictive housing.[75] He repeatedly self-harmed and expressed suicidal ideation while in restrictive housing, sometimes indicating that he was doing so in order to get mental health treatment or because of boredom or anger caused by long stays in restrictive housing.[76] His acting out increased while in restrictive housing at an adult facility to the point that he urinated out his door and threw his feces onto the ground and then

[69] NDCS 110096.

[70] NDCS 109792.

[71] NDCS 112893.

[72] NDCS 115814.

[73] NDCS 112894.

[74] NDCS 112901; NDCS 112892.

[75] NDCS 073854-59; NDCS 073806.

[76] NDCS 000698-711.

engaged in self-harm by biting himself.[77] Despite this history, he remains in restrictive housing and has never been housed in the SMHU.

62. Patient M was placed into restrictive housing for nearly a month despite severe delusions, including that prison staff members were trying to steal her toes and fingers; that her cell was full of snakes; and that she was not a human, but rather was a dolphin.[78] NDCS mental healthcare providers noted that placement in restrictive housing appeared to cause her to deteriorate, as, once in restrictive housing, she began refusing meals, refusing direct orders, and contaminating her own cell.[79] She was placed into restrictive housing rather than the residential mental health program at NCCW despite a documented history of self-harm and attempted suicide serious enough to require hospitalization.[80]

63. Plaintiff Hannah Sabata has been diagnosed with, *inter alia*, Bipolar Disorder, a serious mental illness.[81] She also has had numerous incidents of self-harm and suicidality, both before and after her incarceration.[82] Despite this history, she has spent significant time in restrictive housing, including a continuous one-year period.[83]

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[77] NDCS 073855.

[78] NDCS 096298-99.

[79] NDCS 096300.

[80] Id.

[81] NDCS 073993.

[82] NDCS 018562.

[83] NDCS 016918; NDCS 016947; NDCS 016952; NDCS 016958; NDCS 016968; NDCS 016973; NDCS 016991; NDCS 017105.

64. Ms. Sabata told mental health staff that being forced to stay in her room was causing her mental and physical distress and requested that she be allowed to leave.[84] She has further requested residential mental health treatment which, in light of her significant mental health needs and thoughts of self-harm, is available at NCCW.[85] In one instance, after being placed in restrictive housing, she decompensated to the point of no longer drinking water or eating food until she passed out and was unresponsive.[86] Immediately after being treated, she was returned to restrictive housing where she remained for nearly a year.[87]

65. I also reviewed the critical incident reports for two suicides that occurred in the restrictive housing units in the last two years. One occurred on May 22, 2018 at Tecumseh State Correctional Institution (TSCI).[88] The prisoner was found hanging in his cell at 6:55 AM. Security checks were documented at 6:12 AM and 6:50 AM, but video of the unit shows that the latter check did not occur.[89] The prisoner had been in restrictive housing since at least March 16, 2018.[90]

66. The second suicide occurred on May 9, 2016 in the restrictive housing unit of TSCI.[91] Here, too, the prisoner was found hanging in his cell. He had been in restrictive housing since January 9, 2016, despite a diagnosis of Adjustment Disorder and Major Depressive

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[84] NDCS 074002.

[85] NDCS 074050-51.

[86] NDCS 018564.

[87] NDCS 018565.

[88] Internal Critical Incident Report, May 22, 2018 (NDCS 264719- NDCS 264778).

[89] Id. at NDCS 264723.

[90] Id. at NDCS 264755.

[91] Internal Critical Incident Report, May 6, 2016 (NDCS 245268- 94).

Disorder.[92] Major Depressive Disorder is recognized as a serious mental illness under Nebraska law. NEB. REV. STAT. § 44-792(5)(b). The records indicate that the prisoner was not seen by any mental health care providers or psychiatrists in the 40 days prior to the suicide, despite being diagnosed with serious mental illness and receiving prescribed psychiatric medication from prison staff. In addition, the file contains an inmate interview request from him in which he stated "I can't stand it any longer; nobody helps."[93]

67. These two cases tragically illustrate the type of serious risks to which prisoners are subjected in restrictive housing, including receiving inadequate care for their serious mental illnesses, suffering mental deterioration caused by severe forms of prison isolation (especially for prisoners with pre-existing psychological vulnerabilities), and failing to receive meaningful oversight and monitoring by staff.

68. All of the NDCS restrictive housing units I inspected were extremely similar to one another, in the numerous ways I have described above. They are uniform in policy and practice, and they all appear capable of having truly harmful—even devastating and fatal—impacts on the prisoners housed in them. However, one unit is even more toxic than the rest—the Control Unit (referred to by prisoners and staff alike as "South Forty") at the Nebraska State Penitentiary. Conditions inside this unit were shocking and the condition of many of the prisoners truly dire. I am not sure I have ever seen a unit run quite like "South Forty." The cells are small,[94] many of them very dirty (one that I entered appeared to have dried feces on the walls[95]), with solid metal doors that are essentially windowless (only a small opening looks out

[92] Id. at NDCS 245270-71.

[93] Id. at NDCS 245279-80.

[94] See **Exhibit 2**, NDCS084312 and NDCS084315.

[95] See id., NDCS084228.

onto the walkway outside the cells[96]). Prisoners complained that their cells and the housing unit itself were infested with insects and rodents. In addition to the oppressive atmosphere inside the unit, it operates a truly bizarre system of sick call and mental health monitoring in which staff members must literally navigate through a plumbing or utility chase or "tunnel"[97] (as the officers referred to it) that runs between the two sides of the units, and peer through an opening in the rear of the individual cells to communicate with prisoners, assess their medical and mental health needs, provide them with their medications, and so on.

69. In addition to this bizarre arrangement, I also witnessed prisoners receiving "mental health counseling" in another area of the "South Forty" unit, literally out in the open entranceway to the unit, within sight and sound of various staff members who were coming and going in the course of the session. There is apparently no other more appropriate space available where these sensitive interactions can occur. In several decades of inspecting prisons and jails throughout the country, I have never seen anything quite like it – and with good reason. In my opinion, conditions inside this unit were so extreme that it should be closed, as soon as possible.

70. In summary, the restrictive housing units that I inspected constitute what is meant in correctional practice and in the scientific literature as "solitary confinement" and the group of prisoners who are housed in these units are being subjected to what is considered a dangerous form of isolation. This means that the research I discussed in the preceding section of this Declaration about the significant risk of serious psychological harm is directly applicable to these NDCS units. I reach this conclusion based on my own observations of the units themselves, my interviews with staff and with prisoners housed in the units, and my review of NDCS

[96] See id., NDCS084308 (showing that the cells face towards the inside of the building).

[97] See id., NDCS084332-34.

documents containing policies, procedures, and directives, as well as individual prisoner records. It is my opinion that these conditions of extreme social isolation and social deprivation are similar if not identical to those I have seen and studied in other correctional institutions. These harsh, severe conditions of confinement are precisely the kind that create a substantial risk of serious harm for all the prisoners who are subjected to them. And, as I noted earlier, a growing number of NDCS prisoners appear to be subjected to these kinds of conditions.

71. It is also important to note that the fact that some minority of these prisoners may be housed with cellmates (i.e., are "double-celled") does not mitigate, and indeed may exacerbate, the psychological impact of the nature of their confinement. The kind of forced and strained "interactions" that take place between prisoners who are confined nearly around-the-clock in a small cell hardly constitute meaningful social contact. In fact, under these harsh and deprived conditions, the forced presence of another person may become an additional stressor and source of tension (even conflict) that exacerbates some of the negative reactions brought about by this kind of segregated confinement. Indeed, in my experience, assaults (and sometimes lethal violence) between cellmates who are in isolated confinement is a serious problem in these kinds of units.[98]

72. In addition, as I noted in passing above, it was evident that an extraordinarily high percentage of persons housed in one or another NDCS restrictive housing unit are mentally ill. It appears that little or no effort is made to ensure that individuals with SMI are excluded from these dangerous solitary confinement conditions. Numerous prisoners in the facilities I inspected

[98] In fact, this type of violence has already occurred in NDCS restrictive housing units where individuals are double-celled and a death resulted. See Bill Kelly, Nebraska Prisons Still Housing Two Inmates in Single Occupancy Cells; No Change Expected, NET/PBS/NPR, Dec. 28, 2018, available at http://netnebraska.org/article/news/1133023/nebraska-prisons-still-housing-two-inmates-single-occupancy-cells-no-change.

reported having been placed on the NDCS mental health caseload (often following a lengthy psychiatric history in the free world) and prescribed psychotropic medications for a wide range of very serious mental illnesses. In many instances they reported, and their mental health files corroborated, very serious psychiatric incidents in prison, including self-harm and suicidality. Yet, when I encountered them on my tours, they were housed in restrictive housing, and some of them reported being there for very long periods of time. They consistently complained that they received very little if any regular, meaningful mental health care despite, as they reported, having repeatedly requested it. Placing seriously mentally ill prisoners in solitary confinement is contrary to sound correctional and clinical practice, and a violation of international human rights standards.

73. I should also note that the placement of seriously mentally ill prisoners in isolated confinement is not only harmful to them, but also increases the risks and harmfulness of isolated confinement for other prisoners as well. Out-of-control mentally ill prisoners whose conditions often worsen in isolated confinement may become assaultive to staff and other prisoners, may engage in loud and otherwise noxious behavior (e.g., smearing themselves in feces), and precipitate forceful interventions (e.g., the use of chemical agents) that adversely affect the well-being of everyone in the housing unit.

VI. Conclusion

74. As I noted at length above, there is a robust scientific literature that establishes the adverse psychological effects of solitary or isolated confinement and the severe risk of harm to all prisoners who are subjected to it.

75. For a variety of previously stated reasons, mentally ill prisoners are particularly vulnerable to the painful stressors of isolated confinement and the risk of harm from their placement in such units is especially grave. Indeed, many prison systems voluntarily refrain from

placing them there and, in other jurisdictions, courts have prohibited correctional officials from housing mentally ill prisoners in isolation. In my professional opinion prisoners with a diagnosis of severe mental illness should be categorically excluded from isolation housing, because they face a substantial risk of very serious harm in that setting.

76. Based on my inspections of NDCS facilities, the information provided by prisoners and staff members in the course of my tours, and the documents that I have reviewed, I have concluded that "restrictive housing" in Nebraska represents a harsh form of solitary confinement, one that places all prisoners at significant risk of serious psychological harm. This is the case across the various "restrictive housing" units in NDCS. Indeed, the restrictive housing units that I inspected in NDCS are similar if not identical to those I have studied elsewhere and identified as causing serious adverse effects for the individuals incarcerated therein. They are also precisely the kind of units that have been characterized as "solitary confinement" in the scientific literature where many adverse psychological effects have been documented.

77. Contrary to sound correctional and clinical practice, the weight of psychological and psychiatric opinion, and international human rights standards, NDCS currently houses seriously mentally ill prisoners in its restrictive housing units. Their failure to exclude mentally ill prisoners from these units places them at an unreasonable risk of grave harm. The harms that they and other prisoners in these units are at risk of are extremely serious and sometimes irreversible, including loss of psychological stability, impaired mental functioning, self-mutilation, and even death.

78. Based on many years of experience working with correctional systems and the federal courts to address these issues in different states across the country, I am confident that the problems I have identified in the NDCS restrictive housing conditions, policies, and practices can be effectively addressed through system-wide relief that is ordered by the courts.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 13th day of February, 2019.

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

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