

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ARTHUR JOHNSON,

Plaintiff,

v.

JOHN WETZEL, Secretary of the Pennsylvania Department of Corrections (DOC), SHIRLEY MOORE-SMEAL, Executive Deputy Secretary of the DOC; MICHAEL WENEROWICZ, Regional Deputy Secretary of the DOC; BRENDA TRITT, Superintendent SCI Frackville; JAMES MEINTEL, Deputy Superintendent SCI Frackville, ANTHONY KOVALCHIK, Deputy Superintendent SCI Frackville.
Defendants.,

Defendants.

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

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I. SUMMARY OF EXPERT QUALIFICATIONS

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

2. I have published numerous scholarly articles and book chapters on topics in law and psychology, including encyclopedia and handbook chapters on the backgrounds and social histories of persons accused of violent crimes, the psychological effects of imprisonment, and the nature and consequences of solitary or “supermax”-type confinement. In addition to these scholarly articles and book chapters, I have published two sole-authored books: *Death by Design: Capital Punishment as a Social Psychological System* (Oxford University Press, 2005), and *Reforming Punishment: Psychological Limits to the Pains of Imprisonment* (American Psychological Association Books, 2006).

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, including the Palo Alto Police Department, various California Legislative Select Committees, the National Science Foundation, the American Association for the Advancement of Science, and the United States Department of Justice. For example, in the summer of 2000, I was invited to attend and participated in a White House Forum on the uses of science and technology to improve crime and prison policy, and in 2001 I participated in a conference jointly sponsored by the United States Department of Health and Human Services (DHHS) concerning government policies and programs that could better address the needs of formerly incarcerated persons as they were reintegrated into their communities. I continued to work with DHHS on the issue of how best to insure the successful reintegration of prisoners into the communities from which they have come. More recently, I consulted with the Department of Homeland Security and Department of Defense on detention-related issues, served as both a consultant to and an expert witness before the

United States Congress and, most recently, I have briefed members of the White House Domestic Policy Advisory Council, representatives of the United States Department of Justice, and members of Congress several times in Washington, DC on prison and isolation reform-related issues in the last several years. I also serve on the National Advisory Board for the Vera Institute's Safe Alternatives to Segregation Initiative.

5. In 2012, I testified as an invited witness in an historic hearing in the United States Senate in 2012, before Senator Richard Durbin's subcommittee, in the first ever such hearing to address problematic aspects of solitary confinement and prison isolation policies and practices. Also in 2012, I was appointed to a National Academy of Sciences committee addressing the causes and consequences of high rates of incarceration in the United States and, along with my fellow committee members, published a book-length analysis of that issue, which was the culmination of two years of our collective study.¹ In addition, in 2013, I was promoted to Distinguished Professor of Psychology, the highest level of the professoriate in the University of California system, and in 2015 was selected as the Annual Distinguished Faculty Research Lecturer from among the entire UC Santa Cruz faculty, as well as named UC Presidential Chair, 2015-2018. A copy of my curriculum vitae is attached to this Expert Report as Exhibit 1.

¹ National Research Council, The Growth of Incarceration in the United States: Exploring Causes and Consequences. Committee on Causes and Consequences of High Rates of Incarceration, J. Travis, B. Western, and S. Redburn (Editors). Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press (2014).

6. My academic interest in the psychological effects of various prison conditions is long-standing and dates back to 1971, when I was still a graduate student. I was one of the principal researchers in what has come to be known as the “Stanford Prison Experiment,” in which my colleagues Philip Zimbardo, Curtis Banks, and I randomly assigned normal, psychologically healthy college students to the roles of either “prisoner” or “guard” within a simulated prison environment that we had created in the basement of the Psychology Department at Stanford University. The study has since come to be regarded as a “classic” study in the field of social psychology, demonstrating the power of institutional settings to change and transform the people who enter them.²

7. 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, Colorado, Florida, Georgia, Idaho, Louisiana, Massachusetts, Montana, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Tennessee, Texas, Utah,

² 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).

and Washington), many maximum security federal prisons (including the Administrative Maximum or “ADX” facility in Florence, Colorado), as well as prisons in Canada, Cuba, England, Hungary, Mexico, and Russia. I also have conducted numerous interviews with correctional officials, guards, and prisoners to assess the impact of penal confinement, and statistically analyzed aggregate data from numerous correctional documents and official records to examine the effects of specific conditions of confinement on the quality of prison life and the ability of prisoners to adjust to them.³

8. Over the last several decades, a significant amount of my research and writing about prison-related issues has focused on a specific topic—the psychological effects of isolated, solitary, or “supermax”-type confinement in which prisoners are confined to their cells more or less continuously (typically, on average, 22 hours or more per day).⁴

³ 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, *Psychology and Prison Pain: Confronting the Coming Crisis in Eighth Amendment Law*, 3 *Psychology, Public Policy, and Law*, 499-588 (1997); Craig Haney, *The Consequences of Prison Life: Notes on the New Psychology of Prison Effects*, in D. Canter & R. Zukauskienė (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*, 77 *University of Missouri-Kansas City Law Review* 911-946 (2009); Craig Haney, *Counting Casualties in the War on Prisoners*, 43 *University of San Francisco Law Review* 87-138 (2008); Craig Haney, *The Perversions of Prison: On the Origins of Hypermasculinity and Sexual Violence in Confinement*, 48 *American Criminal Law Review*, 121-141 (2011) [Reprinted in: S. Ferguson (Ed.), *Readings in Race, Ethnicity, Gender and Class*. Sage Publications (2012)]; Craig Haney, *Prison Effects in the Age of Mass Imprisonment*, *The Prison Journal*, 92, 1-24 (2012); and Craig Haney, *Prison Overcrowding*, in B. Cutler & P. Zapf (Eds.), *APA Handbook of Forensic Psychology* (pp. 415-436). Washington, DC: APA Books (2015).

⁴ See: Craig Haney, *Infamous Punishment: The Psychological Effects of Isolation*, 8 *National Prison Project Journal* 3 (1993); Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, *Crime & Delinquency*, 49, 124-156 (2003); Craig Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 *Criminal Justice and Behavior* 956-984 (2008); Craig Haney, *The Social Psychology*

9. I have been qualified and have testified as an expert in various federal courts, including United States District Courts in Arkansas, California, Georgia, Hawaii, New Mexico, Pennsylvania, South Carolina, Texas, and Washington, and in numerous state courts, including courts in Alabama, 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.

10. 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.⁵

11. A statement of compensation and a list of the cases that I have testified in as an expert at trial or by deposition during the last four years are included in an attachment to this Expert Report, as Exhibit 2.

II. BASIS OF EXPERT OPINION

12. I have requested, been provided, and reviewed a number of documents that pertain directly to Mr. Johnson's case. They include: the

of Isolation: Why Solitary Confinement is Psychologically Harmful, Prison Service Journal, 12 (January, 2009); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: The Psychological Consequences of Solitary and Supermax Confinement*, 23 New York University Review of Law and Social Change 477-570 (1997); and Craig Haney, Joanna Weill, Shirin Bakhshay, and Tiffany Winslow, *Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful*, 96 The Prison Journal 126-152 (2016).

⁵ For example, see *Brown v. Plata*, 131 S.Ct. 1910 (2011).

undated Complaint in Arthur Johnson v. John Wetzel et al.; two separate statements of the DOC's administrative custody policy, Pennsylvania DOC Policy Statement on Administrative Custody Procedures (DC-ADM 802), one effective June 7, 2011, and a second effective November 19, 2013; a set of Mr. Johnson's official, filed grievances (DC-ADM 804)

13. I also have some direct knowledge of conditions of confinement in at least some of the Pennsylvania DOC facilities, especially the isolation units (including some units that are at issue in Mr. Johnson's case). Specifically, I toured and inspected conditions of confinement in SCI Huntingdon in the 1980s, in conjunction with a California capital case on which I served as an expert. In addition, in March, 2013, in conjunction with a federal capital case on which I served as an expert, I toured and inspected the isolation units in SCI Greene and, once again, at SCI Huntingdon

14. In addition, I interviewed Mr. Johnson at SCI Frackville on January 26, 2016.

III. SUMMARY OF EXPERT OPINIONS

15. I have been asked to summarize, generally, the extensive scientific literature that now exists on the psychological effects of solitary confinement as well as the professional, correctional, and human rights consensus that has emerged over the last decade concerning its use. In addition, I have been asked to assess both the nature and duration of Mr. Johnson's confinement, and to address the psychological effects that he

has suffered as a result of those conditions and that duration of exposure. I have reached all of my opinions in this matter to a reasonable degree of scientific certainty, and is based upon a foundation and analytical approach well-accepted within my field of expertise. I summarize these opinions briefly in the few paragraphs that follow and in much more detail in the remainder of this Declaration.

16. The living conditions to which the Pennsylvania DOC has subjected Mr. Johnson constitute precisely the kinds of conditions of confinement that scientific theory and a sizable empirical literature have established create grave risks of serious psychological damage and harm. Although that knowledge has existed for quite some time—more than a century—it has been significantly broadened and considerably deepened in recent years. More troubling, Mr. Johnson has, in fact, suffered precisely the types of damage and harm that the scientific literature would predict.

17. As I will discuss in detail below, there is also a scientific, correctional, and human rights consensus about the painfulness and harmfulness of punitive isolation that has existed for a number of years. Here, too, that consensus has been significantly broadened and considerably deepened in recent years, especially in the last ten years.

18. The Pennsylvania DOC has subjected Mr. Johnson to extremely adverse conditions of confinement (and therefore to the psychological pain and significant risk of serious psychological harm that they are known to incur) for an almost unbelievable, unprecedented length of time. Mr. Johnson's situation is almost unique in its severity. I have conducted research and assessed the effects of isolated confinement since the late 1970s, and I have interviewed many hundreds of persons confined in solitary and "supermax"-type confinement. I have encountered no more

than a handful of people in the United States who have been kept in isolation for the length of time that Mr. Johnson has endured.

19. The Pennsylvania DOC has exacerbated Mr. Johnson's extremely long period of confinement in solitary by denying him anything more than superficial psychological monitoring and care despite clear, substantiated risks to his psychological well-being. In addition, the Pennsylvania DOC does not appear to have provided a clear explanation for why Mr. Johnson continues to be kept in isolation (despite years of conforming behavior), and has not provided Mr. Johnson with any opportunity or pathway to reduce his period of solitary confinement (i.e., he has not been told what he can do to make his suffering end). Thus, he continues to be subjected to severe psychological pain without a clear rationale or the means with which to reduce or end it.

20. Mr. Johnson is now approaching his mid-60s and has spent more than half of his life—virtually all of his adult life—living in isolation, alone in his cell. Notwithstanding his significant resiliency and past ability to withstand his harsh and deprived conditions of confinement without completely breaking down or decompensating psychologically, his age-related psychological vulnerability has placed him in an especially precarious and dangerous state.

21. Like other prisoners whom I have interviewed who have been subjected to extremely long-term isolation, Mr. Johnson is suffering from what can be termed “social death”—having few if any meaningful social contacts from which to derive nurturing support for so many years, becoming acutely aware of the deep losses he suffered throughout this long ordeal, recognizing his withering connections to family, friends, and others, and facing his increasing inability to function as a social being. The

many years of painful and harmful isolated confinement have taken a toll and, combined with the psychological fragility that comes from his advanced age, have exacerbated his pain and increased his risk of harm. Mr. Johnson reported to me that he can feel himself faltering and that his mental state has recently, noticeably deteriorated. He feels he has reached and clearly exceeded the limits of his considerable tolerance and resiliency.

22. Remarkably, despite Mr. Johnson's faltering mental health, he has maintained consistently nonviolent and conforming prison behavior. Thus, other than the acts that resulted in his placement in punitive isolation many years ago, he has not engaged in any violent behavior in prison or committed any acts that were overtly disrespectful to staff for decades.

23. Whatever justification the Pennsylvania DOC may have had for placing Mr. Johnson in isolation in the distant past, his long-standing nonviolent prison record and his increasing age provide ample evidence that those justifications no longer exist. In fact, based on my experience of more than 40 years researching solitary confinement, interviewing and evaluating people held in isolation, and participating in litigation on this issue, I can perceive no current, legitimate penological justification for retaining him in punitive isolation any longer. And, against this absence of penological justification, the increasing level of risk to his psychological and physical well-being if he remains there looms even larger.

24. Finally, there can be no doubt that Mr. Johnson's decades of solitary confinement have exacted a significant toll on his psychological well being. As a matter of sound correctional practice and as an essential psychological safeguard, Mr. Johnson's release from isolated confinement

should be done immediately but only in stages, ideally as part of a meaningful and thoughtfully structured “step down” program in recognition of the damage already inflicted. Mr. Johnson has been deprived of normal social contact and social interaction for three-and-a-half decades. He will need to become gradually familiar with, and be eased back into, the norms of social life.

IV. THE SCIENTIFIC, CORRECTIONAL, AND HUMAN RIGHTS CONSENSUS CONCERNING THE ADVERSE PSYCHOLOGICAL EFFECTS OF PUNITIVE ISOLATION

25. The effects being housed in solitary or isolated confinement—especially over a long period of time—are now well understood and described in the scientific literature. There are numerous empirical studies that report “robust” findings—that is, the findings have been obtained in studies that were conducted by researchers and clinicians from diverse backgrounds and perspectives, were completed and published over a period of many decades, and are empirically very consistent.⁶ 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 to which they are exposed.

26. In addition, the empirical conclusions are theoretically sound. That is, there are straightforward scientific explanations for the fact that long-term isolation—the absence of meaningful social contact and interaction with others— and the other severe deprivations that typically occur under conditions of isolated or solitary confinement have harmful psychological consequences. Social exclusion and isolation from others is

⁶ See the reviews of this literature summarized in my various publications listed *supra* at note 4.

known to produce adverse psychological effects in contexts other than prison; it makes perfect theoretical sense that this experience produces similar negative outcomes in correctional settings, where the isolation is so rigidly enforced, the social opprobrium that attaches to isolated prisoners can be extreme, and the other associated deprivations are so severe. The scientific literature on isolation, as well as my own research and experience, indicate that “long-term” exposure to precisely the kinds of conditions and practices that—based on my own personal inspections, the United States Department of Justice reports on them, and Mr. Johnson’s descriptions of his conditions of confinement—clearly currently exist in the Pennsylvania DOC and to which Mr. Johnson has himself been subjected over a period of three-and-a-half decades. The significant risk of grave psychological harm is brought about whether or not the prisoners subjected to these conditions suffer from a pre-existing mental illness.

27. It should be noted, as I will discuss in more detail in several later paragraphs, that “long-term” or “prolonged” exposure to prison isolation is generally used in the literature to refer to durations of solitary confinement that are substantially briefer than the amount of time that Mr. Johnson been subjected to it in Pennsylvania. For example, the American Psychiatric Association (APA) defined “prolonged segregation” as segregation lasting for four weeks or longer (which the APA also said “should be avoided” for the seriously mentally ill).⁷ Thus, Mr. Johnson has been subjected to a duration of isolated confinement that far exceeds—by a substantial order of magnitude (approaching 500 times longer)—the

⁷ American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (2012), available at http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf

amounts typically reported in the literature, studied by researchers, and considered psychiatrically problematic.

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

[S]egregation from the mainstream prisoner population in attached housing units or free-standing facilities where prisoners are involuntarily confined in their cells for upwards of 23 hours a day or more, given only extremely limited or no opportunities for direct and normal social contact with other persons (i.e., contact that is not mediated by bars, restraints, security glass or screens, and the like), and afforded extremely limited if any access to meaningful programming of any kind.⁸

29. This definition is similar to the one employed by the National Institute of Corrections (NIC), as cited by Chase Riveland in a standard reference work on solitary-type confinement that was sponsored and disseminated by the United States Department of Justice. Riveland noted that the NIC itself had defined solitary or “supermax” housing as occurring in a “freestanding facility, or a distinct unit within a freestanding facility, that provides for the management and secure control of inmates” under conditions characterized by “separation, restricted movement, and limited

⁸ Haney, *The Social Psychology of Isolation*, *supra* note 4, at footnote 1.

access to staff and other inmates.”⁹ More recently, the Department of Justice employed a similar definition, noting that “the terms ‘isolation’ or ‘solitary confinement’ mean the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others... An isolation unit means a unit where all or most of those housed in the unit are subjected to isolation.”¹⁰

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

30. In the admitted absence of a single “perfect” study of the phenomenon,¹¹ there is a substantial body of published literature that clearly documents the distinctive patterns of psychological harm that can

⁹ Chase Riveland, *Supermax Prisons: Overview and General Considerations*. National Institute of Corrections. Washington DC: United States Department of Justice (1999), at p. 3, available at <http://static.nicic.gov/Library/014937.pdf>

¹⁰ United States Department of Justice, Letter to the Honorable Tom Corbett, Re: *Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation*, May 31, 2013, at p. 5 (emphasis in original), available at http://www.justice.gov/crt/about/spl/DC/documents/cresson_findings_5-31-13.pdf, citing also to *Wilkinson v. Austin*, 545 U.S. 209, 214, 224 (2005), where the United States Supreme Court described solitary confinement as limiting human contact for 23 hours per day; and *Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990), where the Third Circuit described it as limiting contact for 21 to 22 hours per day.

¹¹ No more than basic knowledge of research methodology is required to design the “perfect” study of the effects of solitary confinement: 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 (say, two or more years 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). Unfortunately, no more than basic knowledge of the realities of prison life and the practicalities of conducting research in prisons is required to understand why such a study would be impossible to ever conduct. Moreover, any prison system that allowed truly independent, experienced researchers to perform even a 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.

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 or “supermax” confinement. The studies have now spanned a period of over four decades, and were conducted in locations across several continents by researchers with different professional expertise, ranging from psychiatrists to sociologists and architects.

31. Even prisoners in “isolated confinement” who are “double-celled” (i.e., housed with another prisoner) may nonetheless suffer many of the negative psychological effects that are described in the paragraphs below. In fact, in some ways, prisoners who are double-celled in an isolation unit have the worst of both worlds: they are “crowded” in and confined with another person inside a small cell but—and this is the crux of their “isolation”—simultaneously isolated from the rest of the mainstream prisoner population, deprived of even minimal freedom of movement, prohibited from access to meaningful prison programs, and denied opportunities for any semblance of “normal” social interaction.¹²

32. As I noted in passing above, researchers and practitioners know that meaningful social interactions and social connectedness can have a positive effect on people’s physical and mental health and, conversely, that social isolation in general is potentially very harmful and

¹² This is especially problematic if prisoners are involuntarily double-celled, have little or no choice over the identity of the person with whom they are double-celled, and have no practical or feasible means of changing cellmates if they become incompatible. Even under the best of circumstances, however, double-celling under conditions of otherwise isolated confinement may be difficult for prisoners to accommodate to.

can undermine health and psychological well-being.¹² Not surprisingly, there is now a reasonably large and growing literature on the significant risk that solitary or so-called “supermax” confinement poses for the mental health of prisoners. The long-term absence of meaningful human contact and social interaction, the enforced idleness and inactivity, and the oppressive security and surveillance procedures, and the accompanying hardware and other paraphernalia that are brought or built into these units combine to create harsh, dehumanizing, and deprived conditions of confinement. These conditions predictably can impair the psychological functioning of the prisoners who are subjected to them.¹³ For some prisoners, these impairments can be permanent and life-threatening.

33. In the admitted absence of a single “perfect” study of the phenomenon,¹⁴ there is a substantial body of published literature that

¹² For example, see: Brock Bastian & Nick Haslam, *Excluded from Humanity: The Dehumanizing Effects of Social Ostracism*, *Journal of Experimental Social Psychology*, 46, 107-113 (2010); Stephanie Cacioppo & John Cacioppo, *Decoding the Invisible Forces of Social Connections*, *Frontiers in Integrative Neuroscience*, 6, 51 (2012); DeWall, et al., *Belongingness as a Core Personality Trait: How Social Exclusion Influences Social Functioning and Personality Expression*, *Journal of Personality*, 79, 979-1012 (2011); Damiano Fiorillo & Fabio Sabatini, *Quality and Quantity: The Role of Social Interactions in Self-Reported Individual Health*, *Social Science & Medicine*, 73, 1644-1652 (2011); S. Hafner et al., *Association Between Social Isolation and Inflammatory Markers in Depressed and Non-depressed Individuals: Results from the MONICA/KORA Study*, *Brain, Behavior, and Immunity*, 25, 1701-1707 (2011); Johan Karremans, et al., *Secure Attachment Partners Attenuate Neural Responses to Social Exclusion: An fMRI Investigation*, *International Journal of Psychophysiology*, 81, 44-50 (2011); 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).

¹³ For example, see: 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); Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, *supra* note 4; 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).

¹⁴ No more than basic knowledge of research methodology is required to design the “perfect” study of the effects of solitary confinement: dividing a representative sample of prisoners (who had never been in solitary confinement) into two groups by randomly

clearly documents the distinctive patterns of 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 or “supermax” confinement. The studies have now spanned a period of over four decades, and were conducted in locations across several continents by researchers with different professional expertise, ranging from psychiatrists to sociologists and architects.¹⁵

34. For example, mental health and correctional staff who have worked in disciplinary segregation and isolation units have reported observing a range of problematic symptoms manifested by the prisoners confined in these places. The authors of one of the early studies of solitary

assigning half to either a treatment condition (say, two or more years 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). Unfortunately, no more than basic knowledge of the realities of prison life and the practicalities of conducting research in prisons is required to understand why such a study would be impossible to ever conduct. Moreover, any prison system that allowed truly independent, experienced researchers to perform even a 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.

¹⁵ For example, in addition to the literature reviews contained in my own published writing on these issues, cited *supra* at note 4, see: Arrigo, B., & Bullock, J., *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); and Smith, *The Effects of Solitary Confinement on Prison Inmates*, *supra* note 14. My own work on these issues builds on the work of those other researchers and my findings and conclusions are consistent with and corroborative of them.

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.”¹⁶

35. 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.¹⁷ 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, a build-up of physiological and psychic tension that led to incidents of self-mutilation.¹⁸ 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.”¹⁹

36. More recent studies have identified other symptoms that appear to be produced by these conditions. Those symptoms include:

¹⁶ Bruno M. Cormier & Paul J. 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).

¹⁷ Hans Toch, *Men in Crisis: Human Breakdowns in Prisons*. Aldine Publishing Co.: Chicago (1975).

¹⁸ *Id.* at 54.

¹⁹ *Ibid.*

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.²⁰

²⁰ In addition to the numerous studies cited in the articles referenced *supra* at notes 4 and 11, there is a significant international literature on the adverse effects of solitary confinement. For example, see: Henri N. Barte, *L'Isolement Carcéral*, Perspectives Psychiatriques, 28, 252 (1989). Barte analyzed what he called the “psychopathogenic” effects of solitary confinement in French prisons and concluded that prisoners placed there for extended periods of time could become schizophrenic instead of receptive to social rehabilitation. He argued that the practice was unjustifiable, counterproductive, and “a denial of the bonds that unite humankind.” In addition, see: Reto Volkart, *Einzelhaft: Eine Literaturübersicht* (Solitary confinement: A literature survey), Psychologie -Schweizerische Zeitschrift für 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 über Psychopathologische Effekte der Einzelhaft* (A controlled investigation on psychopathological effects of solitary confinement), Psychologie - Schweizerische Zeitschrift für 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 für 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 Człowieka 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

37. In addition, a number of correlational studies have been done examining 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 security housing or SHU, 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.²¹ 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.”²² Similarly, a team of researchers in New York recently reported that “[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm after we controlled for the length of jail stay, SMI [whether the

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.

²¹ 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.

²² *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).

inmate was seriously mentally ill], age, and race/ethnicity.”²³ 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.²⁴

38. The empirical consensus on the harmfulness of isolated or solitary-type confinement is very broad. I say that despite the fact that there is one study that has been cited for a different conclusion. The so-called “Colorado Study” of one year in “administrative segregation,” is sometimes referenced as evidence that isolated confinement does not pose a significant risk to the psychological well-being of inmates. In addition to the fact that the Colorado Study focused on one year in administrative segregation, as opposed to the core issue in the present case—the effects of severe isolation for more than three-and-a-half decades—there are several other reasons why the Colorado Study is a singularly inappropriate study on which to rely. They establish the fact that this study should not serve as the basis for minimizing or ignoring the grave risk of “psychological

²³ Fatos Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, *American Journal of Public Health*, 104, 442-447 (2014), at p. 445.

²⁴ 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).

damage to inmates” that occurs in isolation units like those at issue in Mr. Johnson’s case.

39. For one, the Colorado Study has been roundly criticized by a number of researchers from a variety of disciplines (psychology, psychiatry, anthropology, history, and law) as deeply flawed in its methodology. Many of these experts have published critiques of the study in which they conclude that its methodological problems are so severe as to render the results uninterpretable.²⁵

40. These and other kinds of methodological problems led well-known prison researchers David Lovell and Hans Toch to note in their critique of the study that “[d]espite the volume of the data, no systematic interpretation of the findings is possible.”²⁶ Many other published criticisms of the study’s methodology reached similar conclusions.²⁷

²⁵ The serious methodological problems include: the inappropriate exposure of all groups to the key treatment variable (isolation); the continued cross-contamination of the general population and administrative segregation groups throughout the study (confounding the interpretation of any differences or similarities between them); the use of a convenience and patchwork sample rather than a representative group of participants; the failure to record (and, therefore, the inability to quantify or code) the exact nature of the conditions of confinement (especially, the amount or degree of isolation) to which each participant or group of participants was exposed; employing a single, inexperienced research assistant with only a bachelor’s degree (who wore a badge identifying her to the prisoners as a department of corrections employee) to collect *all* of the study data; problematic instances in which the research assistant questioned the truthfulness of the prisoners’ responses and required them to “redo” the tests being administered; the total reliance on self-reported rating scales that were created through the disaggregation and reconstruction/recombination of subscales taken from other test batteries that had not been validated with prisoner populations; and the failure to utilize even a basic interview with the study participants or to make use of the behavioral observational data that were collected (that appeared at odds with the prisoner self reports).

²⁶ David Lovell & Hans Toch, *Some Observations about the Colorado Segregation Study*, Correctional Mental Health Report, May/June 2011, 3-4, 14.

²⁷ For example, see: Stuart Grassian & Terry Kupers, *The Colorado Study Versus the Reality of Supermax Confinement*, Correctional Mental Health Report, May/June 2011, 1-4; Lorna A. Rhodes & David Lovell, *Is Adaptation the Right Question? Addressing the Larger Context of Administrative Segregation: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental Health, June 21, 2011, 1-9, available at <http://community.nicic.gov/cfs->

41. In addition, two of the study's other authors, Jeffrey Metzner and Jamie Fellner, have published an article concluding that "[i]solation can be harmful to any prisoner," that the potentially adverse effects of isolation include "anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis."²⁸ In fact, their deep concerns over the harmfulness of isolated conditions of confinement led them to recommend that professional organizations "should actively support practitioners who work for changed segregation policies and they should use their institutional authority to press for a nationwide rethinking of the use of isolation" in the name of their "commitment to ethics and human rights."²⁹

file.ashx/___key/CommunityServer.Components.PostAttachments/00.00.05.95.19/Supermax-_2D00_-T-_2D00_-Rhodes-and-Lovell.pdf; Sharon Shalev & Monica Lloyd, *If This Be Method, Yet There Is Madness in It: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental Health, June 21, 2011, 1-7, available at http://community.nicic.gov/cfs-file.ashx/___key/CommunityServer.Components.PostAttachments/00.00.05.95.21/Supermax-_2D00_-T-_2D00_-Shalev-and-Lloyd.pdf; and Peter Scharff Smith, *The Effects of Solitary Confinement: Commentary on One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*, Corrections & Mental Health, June 21, 2011, 1-11, available at http://community.nicic.gov/cfs-file.ashx/___key/CommunityServer.Components.PostAttachments/00.00.05.95.22/Supe rmax-_2D00_-T-_2D00_-Smith.pdf.

²⁸ Jeffrey Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, *Journal of the Academy of Psychiatry and Law*, 38, 104-108 (2010), at p. 104, available at http://www.hrw.org/sites/default/files/related_material/Solitary%20Confinement%20and%20Mental%20Illness%20in%20US%20Prisons.pdf.

²⁹ *Id.* at p. 107. In addition to the serious methodological flaws that have been identified in the Colorado Study, and the positions that virtually all of its authors have taken acknowledging the harmful effects of isolation and opposing its use with mentally ill prisoners in particular, the Colorado Department of Corrections itself has moved over the last several years to both very significantly reduce the overall number of prisoners who are housed in isolation units (again, termed "administrative segregation" there). Memo to Wardens from Lou Archuleta, Interim Director of Prisons, Colorado DOC, December 10, 2013. See, also: Jennifer Brown, *Colorado Stops Putting Mentally Ill Prisoners in Solitary Confinement*, *Denver Post*, Dec. 12, 2013, available at http://www.denverpost.com/news/ci_24712664/colorado-wont-put-mentally-ill-prisoners-solitary-confinement.

42. The study's numerous and serious methodological flaws notwithstanding, the authors of the Colorado Study have themselves repeatedly taken public positions that explicitly acknowledge the potentially harmful effects of prolonged prison isolation; most of them have published articles, forwarded recommendations, and drafted position papers in favor of limiting the use of isolation altogether and, among other things, against housing mentally ill prisoners inside these kinds of units.

43. For example, Maureen O'Keefe, a researcher for the Colorado Department of Corrections and the primary author of the study, is on record as favoring significant reductions in the use of prison isolation (or "administrative segregation" as it is known in Colorado). She is also very clear about what she termed a misuse or misinterpretation of the study's results: "[W]e do not believe in any way and we do not promote the study as something to argue for the case of segregation... My interpretation is that people believe that this study sanctions administrative segregation for mentally ill and nonmentally ill alike... I do not believe that the conclusions lend to that and that is not the intended use of our study.³⁰

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

³⁰ Deposition of Maureen O'Keefe at 96, 101 (Oct. 25, 2013), *Sardakowski v. Clements*, No. 1:2012cv01326 (D. Colo. filed May 21, 2012) (Civil Action No. 12-CV-01326-RBJ-KLM).

victims of what are called “deprivation and constraint” torture techniques.³¹

45. The prevalence of psychological symptoms (that is, the percentage of prisoners who are placed in these units who suffer from these and related signs of psychological distress) is often very high. For example, in an early study that I conducted at the Security Housing Unit (SHU) at Pelican Bay State Prison in California, I did systematic assessments of a randomly selected sample of 100 prisoners who were housed there. The sample was randomly selected to ensure that it consisted of a representative group of SHU prisoners. The representativeness of the sample allowed me to estimate the prevalence of psychological trauma and isolation-related pathology among the population of PBSHU prisoners. In fact, I found that every symptom of psychological distress that I measured but one (fainting spells) was suffered by more than half of the prisoners who were interviewed.³² Many of the symptoms were reported by two-thirds or more of the prisoners assessed in this isolated housing unit, and some were suffered by nearly

³¹ 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).

³² See Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement* *supra* note 4.

everyone. Well over half of the prisoners who were isolated in the Pelican Bay SHU reported a constellation of symptoms—headaches, trembling, sweaty palms, and heart palpitations—that are known to be stress-related.

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

47. Although these specific symptoms of psychological stress and the psychopathological reactions to isolation are numerous and well-documented, and provide important indices of the risk of harm to which isolated prisoners are subjected, there are other significant aspects to the psychological pain and dysfunction that solitary confinement can produce, ones that extend beyond these specific and more easily measured symptoms and reactions. Depriving people of normal social contact and meaningful social interaction over long periods of time can damage or distort their social identities, destabilize their sense of self and, for some, destroy their ability to function normally in free society.

48. Psychological science has long recognized the critical role of social contact in establishing and maintaining emotional health and well-being. As one researcher put it: “Since its inception, the field of psychology

emphasized the importance of social connections.”³³ For example, 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.³⁴ 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.³⁵ Prolonged social deprivation is painful and destabilizing in part because it deprives persons of the opportunity to ground their thoughts and emotions in a meaningful social context—to know what they feel and whether those feelings are appropriate.

49. Since this early research was conducted on the importance of affiliation, numerous scientific studies have established the psychological significance of social contact, connectedness and belongingness. They have concluded, among other things, that the human brain is literally “wired to connect” to others.³⁶ Thwarting this “need to connect” not only

³³ DeWall, C., *Looking Back and Forward: Lessons Learned and Moving Forward*, in C. DeWall (Ed.), *The Oxford Handbook of Social Exclusion* (pp. 301-303). New York: Oxford University Press (2013), at p. 301.

³⁴ 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).

³⁵ 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).

³⁶ Lieberman, M., *Social: Why Our Brains Are Wired to Connect*. New York: Random House (2013).

undermines psychological well-being but increases physical morbidity and mortality.

50. Indeed, in part out of recognition of the importance of the human need for social contact, connection, and belongingness, social psychologists and others have written extensively about the harmful effects of its deprivation—what happens when people are subjected to social exclusion and isolation. Years ago, Herbert Kelman argued that denying persons of contact with others was a form of dehumanization.³⁷ More recently, others have documented the ways in which social exclusion is not only “painful in itself,” but also “undermines people’s sense of belonging, control, self-esteem, and meaningfulness, reduces pro-social behavior, and impairs self-regulation.”³⁸ Indeed, the subjective experience of social exclusion results in what have been called “cognitive deconstructive states” in which there is emotional numbing, reduced empathy, cognitive inflexibility, lethargy, and an absence of meaningful thought.³⁹

51. In fact, the editor of an authoritative *Oxford Handbook of Social Exclusion* concluded the volume by summarizing the “serious threat” that social exclusion represents to psychological health and well-being, including “increased salivary cortisol levels... and blood flow to brain regions associated with physical pain,” “sweeping changes” in

³⁷ Kelman, H., *Violence Without Restraint: Reflections on the Dehumanization of Victims and Victimizers*. In G. Kren & L. Rappaport (Eds.), *Varieties of Psychohistory* (pp. 282-314). New York: Springer (1976).

³⁸ Bastian & Haslam, *supra* note 17, at p. 107, internal references omitted.

³⁹ Twenge, J., Catanese, K., & Baumeister, R. (2003). *Social Exclusion and the Deconstructed State: Time Perception, Meaninglessness, Lethargy, Lack of Emotion, and Self Awareness*. *Journal of Personality and Social Psychology*, 85, 409-423 (2003).

attention, memory, thinking, and self-regulation, as well as changes in aggression and prosocial behavior. As he put it: “This dizzying array of responses to social exclusion supports the premise that it strikes at the core of well-being.”⁴⁰

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

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

54. Second, some prisoners cope with the painful, asocial nature of their isolated existence by paradoxically creating even more distance

⁴⁰ DeWall, *supra* note 34, at p. 302.

between themselves and others. For some, the absence of others becomes so painful that they convince themselves that they do not need social contact of any kind—that people are a “nuisance,” after all, and the less contact they have the better. As a result, they socially withdraw further from the world around them, receding even more deeply into themselves than the sheer physical isolation of solitary confinement and its attendant procedures require. Others move from initially being starved for social contact to eventually being disoriented and even frightened by it. As they become increasingly unfamiliar and uncomfortable with social interaction, they are further alienated from others and made anxious in their presence.⁴¹

55. Third, and finally, while these social pathological adaptations are functional and even necessary in the short-term, over time they tend to be internalized and persist long after the prisoner’s time in isolation has ended. Thus, the adaptations move from being consciously employed survival strategies or noticeable reactions to immediate conditions of confinement to becoming more deeply ingrained ways of being. Prisoners may develop extreme habits, tendencies, perspectives, and beliefs that are difficult or impossible to relinquish once they are released. Although their adaptations may have been functional in isolation (or appeared to be so), they are typically acutely dysfunctional in the social world most prisoners are expected to re-enter. In extreme cases, these ways of being are not only dysfunctional but have been internalized so deeply that they become

⁴¹ For evidence that solitary confinement may lead to a withdrawal from social contact or an increased tendency to find the presence of people increasingly aversive or anxiety arousing, see: Cormier, B., & Williams, *supra* note 17; Haney, *supra* note 4; H. Miller & G. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, *Criminal Behaviour and Mental Health*, 7, 85-94 (1997); Scott & Gendreau, *supra* note 21; Toch, *supra* note 18; and Waligora, *supra* note 21.

disabling, interfering with the capacity to live a remotely normal or fulfilling social life. These individuals do not present an increased security risk due to these adverse symptoms of long-term solitary confinement. In fact, I do not believe that Mr. Johnson presents any such security risk. Persons who have been held in long-term solitary confinement are capable of abiding by the rules and regulations of the institution when released to the general prison population. However, their experience in long-term isolation can make their adjustment to general population painful and challenging, especially if the prison administration does not meaningfully assist them in re-socialization.

56. It is also important to note that, although social deprivation is the source of the greatest psychological pain that prisoners experience in solitary confinement, and places them at the greatest risk of harm, prison isolation units deprive prisoners of many other things as well. Solitary confinement typically includes high levels of repressive control, enforced idleness, reduced environmental stimulation, and physical or material deprivations that also produce psychological distress and can exacerbate the negative consequences of social deprivation. Indeed, most of the things that we know are beneficial to prisoners—such as increased participation in institutional programming, contact visits with persons from outside the prison, opportunities for meaningful physical exercise or recreation, and so on⁴²—are either functionally denied or greatly restricted for prisoners who are housed in isolation units. Thus, in addition to the social pathology that is created by the experience of solitary confinement, these other stressors also can produce additional negative psychological effects.

⁴² J. Wooldredge, *Inmate Experiences and Psychological Well-Being*, *Criminal Justice and Behavior*, 26, 235-250 (1999).

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

58. Similarly, apart from the profound social, mental and physical deprivations that solitary confinement can produce, prisoners housed in these units experience prolonged periods of monotony and idleness. Many of them experience a form of sensory deprivation or “reduced environmental stimulation” —there is an unvarying sameness to the physical stimuli that surround them. These prisoners exist within the same limited spaces and are subjected to the same repetitive routines, day in and day out. There is little or no external variation to the experiences they are permitted to have or can create for themselves. They not only see and experience the same extremely limited physical environment, but also have minimal, routinized, and superficial contacts with the same very small group of people, again and again, for years on end. This loss of perceptual and cognitive or mental stimulation may result in the atrophy of important skills and capacities.⁴³

⁴³ For examples of this range of symptoms, see: Brodsky & Scogin, *Inmates in Protective Custody: First Data on Emotional Effects*, Forensic Reports, 1, 267-280 (1988); Grassian, S., *Psychopathological Effects of Solitary Confinement*, American Journal of

59. In addition, conditions of solitary confinement in most prison isolation units deprive prisoners of the opportunity to give and receive caring human touch. This is certainly true of the Pennsylvania isolation units in which Arthur Johnson has been housed, where contact visits are absolutely prohibited. This means that he has gone for decades without ever touching another person with affection. Yet, psychologists have long known that: “Touch is central to human social life. It is the most developed sensory modality at birth, and it contributes to cognitive, brain, and socioemotional development and childhood.”⁴⁴ The need for caring human touch is so fundamental that early deprivation is a risk factor for neurodevelopmental disorders, depression, suicidality, and other self destructive behavior.⁴⁵ Later deprivation is associated with violent behavior in adolescents.⁴⁶ Recent theory and research now indicate that “touch is a primary platform for the development of secure attachments and cooperative relationships,” is “intimately involved in patterns of caregiving,” is a “powerful means by which individuals reduce the

Psychiatry, 140, 1450-54 (1983); Haney, *supra* note 4; Miller & Young, *supra* note 42; and Volkart, et al., *supra* note 21.

⁴⁴ Hertenstein, M., Keltner, D., App, B., Buleit, B., & Jaskolka, A., *Touch Communicates Distinct Emotions*. Emotion, 6, 528-533 (2006), at p. 528. See, also: Hertenstein, M., & Weiss, S. (Eds.), The Handbook of Touch: Neuroscience, Behavioral, and Health Perspectives. New York: Springer (2011).

⁴⁵ For example, see: Cascio, C., *Somatosensory Processes in Neurodevelopmental Disorders*. Journal of Neurodevelopmental Disorders, 2, 62-69 (2010); Field, S., *Touch Deprivation and Aggression Against Self Among Adolescents*, in Stoff, D. & Susman, E. (Ed.), Developmental psychobiology of aggression (117-140). New York: Cambridge (2005).

⁴⁶ Field, T., *Violence and Touch Deprivation in Adolescents*, Adolescence, 37, 735-749 (2002)

suffering of others,” and also “promotes cooperation and reciprocal altruism.”⁴⁷

60. The uniquely prosocial emotion of compassion “is universally signaled through touch,” so that persons who live in a world without touch are denied the experience of receiving or expressing compassion in this way.⁴⁸ Researchers have found that caring human touch mediates a sense of security and place, a sense of shared companionship, of being and nurturing, feelings of worth and competence, access to reliable alliance and assistance, and guidance and support in stressful situations.⁴⁹ A number of experts have argued that caring human touch is so integral to our well being that it is actually therapeutic; it has been recommended to treat a host of maladies including depression, suicidality, and learning disabilities.⁵⁰

61. Not every isolated prisoner will suffer all of the previously described adverse psychological reactions to their severe conditions of confinement. As I will document below, Mr. Johnson has suffered from a high number of them, but still not literally every one. However, the overall

⁴⁷ Goetz, J., Keltner, D., & Simon-Thomas, E., *Compassion: An Evolutionary Analysis and Empirical Review*, *Psychological Bulletin*, *136*, 351-374 (2010), at p. 360.

⁴⁸ Stellar, J., & Keltner, D., *Compassion*, in Tugade, M., Shiota, M., & Kirby, L. (Eds.), *Handbook of Positive Emotions* (pp. 329-341). New York: Guilford (2014)

⁴⁹ Weiss, R., *The Attachment Bond in Childhood and Adulthood*, in C. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment Across the Life Cycle* (66-76). London: Routledge (1995).

⁵⁰ For example, see: Dobson, S., Upadhyaya, S., Conyers, I., & Raghavan, R., *Touch in the Care of People with Profound and Complex Needs*, *Journal of Learning Disabilities*, *6*, 351-362 (2002); Field, T., *Deprivation and Aggression Against Self Among Adolescents*. In D. Stoff & E. Susman(Eds.), *Developmental Psychobiology of Aggression* (pp. 117-140). New York: Cambridge (2005)

nature and magnitude of the negative psychological reactions that I have documented in my own research and that have been reported by others in the literature underscore the stressfulness and painfulness of this kind of confinement, the lengths to which prisoners must go to adapt and adjust to it, and the risk of harm that it creates. The potentially devastating effects of these conditions are reflected in the characteristically high numbers of suicide deaths, incidents of self-harm and self-mutilation that occur in many of these units.

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

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

time. The evidence I have summarized above describes and details the risk of psychological harm that long-term isolation creates, including mental pain and suffering and the increased incidence of self-harm and suicide.

64. The psychological literature underscores the importance of meaningful social contact and interaction, in essence establishing these things as identifiable human needs. Over the long-term, they may be as essential to a person's psychological or mental health as adequate food, clothing, and shelter are to his or her physical well-being.

65. Thus, the existing scientific knowledge on the painful and harmful nature of long-term isolated confinement is long-standing, robust, empirically well-documented, and theoretically sound. In recent years, new insights about the fundamental human need for meaningful social contact and for caring human touch have added theoretical dimensions to the already existing substantial body of empirical data on these issues. These new insights add considerable weight to the long-standing consensus view: the experience of punitive isolation is not only painful but also places prisoners at significant risk of serious psychological harm.

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

66. In addition to the increasingly broad and deep scientific consensus on the painfulness and harmfulness of isolated confinement, a number of state correctional systems have explicitly recognized the psychological risks as well as the added expense and overall ineffectiveness

of punitive isolation and taken steps to significantly reduce its use. A recent New York Times Magazine article is instructive on this issue as well. It reported the current views of Colorado officials, including the head of its Department of Corrections: “Gov. John W. Hickenlooper of Colorado signed [a bill banning solitary confinement for anyone under 21] at the urging of the state corrections chief, Rick Raemisch, who spent a night in solitary confinement and wrote about it in a New York Times Op-Ed. concluding that its overuse is ‘counterproductive and inhumane.’”⁵¹

67. In fact, over the last several years, prison systems as diverse as Maine and Mississippi have drastically reduced the number of prisoners housed in solitary or isolated confinement.⁵² In addition, several states have closed their primary solitary confinement units altogether. For example, in January, 2013, the Illinois Department of Corrections closed its supermax prison located at the Tamms Correctional Center.⁵³ In

⁵¹ Binelli, supra note 1, at p. 40. For the Colorado Executive Director of Corrections Op Ed, see Raemisch, R., My Night in Solitary, New York Times, February 20, 2014 [available at: http://www.nytimes.com/2014/02/21/opinion/my-night-in-solitary.html?_r=0]

⁵² For a discussion of the nature and impact of the reforms to punitive isolation in Mississippi, see Kupers, T., et al., Beyond Supermax Administrative Segregation: Mississippi’s Experience Rethinking Prison Classification and Alternative Mental Health Programs, Criminal Justice & Behavior, 36, 1037- (2009); and Buntin, J., Exodus: How America’s Reddest State—And Its Most Notorious Prison—Became a Model of Corrections Reform, Governing, 23, 20- (2010). For a discussion of the nature of the reforms to punitive isolation in Maine, see: Heiden, Z., Change Is Possible: A Case Study of Solitary Confinement Reform in Maine, ACLU of Maine, March, 2013 [available at: http://www.aclumaine.org/sites/default/files/uploads/users/admin/ACLU_Solitary_Report_webversion.pdf]; and Tapley, L., Reform Comes to the Supermax, Portland Phoenix, May 25, 2011 [available at: <http://portland.thephoenix.com/news/121171-reform-comes-to-the-supermax/>].

⁵³ See Tamms Correctional Center Closing—Fact Sheet, Illinois Department of Corrections. [available at: <http://www.ilga.gov/commission.cgfa2006/upload/TammsMeetingTestimonyDocuments.pdf>.]

Colorado, in addition to reducing their administrative segregation population by nearly 37%, the Department of Corrections completely shut down a 316-bed ad seg facility.⁵⁴

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

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

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

⁵⁴ News Release, Department of Corrections, The Department of Corrections Announces the Closure of Colorado State Penitentiary II (March 19, 2012) [available at: <http://www.doc.state.co.us/sites/default/files/Press%20release%20CSP%20II%20close%20%20Feb%201%202013.pdf>]

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

70. For example, Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment concluded that solitary confinement for longer than 15 days constitutes torture, and that juveniles and people with mental illness should never be held in solitary confinement.⁵⁵ The American Academy of Child and Adolescent Psychiatry issued a statement opposing “the use of solitary confinement in correctional facilities for juveniles,” stating that “any youth that is confined for more than 24 hours must be evaluated by a mental health professional,” and aligning AACAP with the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, which includes among “disciplinary measures constituting cruel, inhuman or degrading treatment” “closed or solitary confinement or any other punishment that may compromise the physical or mental health of the juvenile concerned.”⁵⁶ American Public Health Association issued a statement in

⁵⁵ Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc A/66/268, ¶¶ 76-78 (Aug. 5, 2011).

⁵⁶ American Academy of Child and Adolescent Psychiatry, Solitary Confinement of Juvenile Offenders (2012) [available at http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx]. Calls for the prohibition of the use of isolated confinement for vulnerable populations such as juveniles underscore the widespread recognition that it is a psychologically painful and potentially very harmful environment. The same message is conveyed by the numerous calls to significantly limit the duration of solitary

which it detailed the public-health harms posed by solitary confinement, urged correctional authorities to “eliminate solitary confinement for security purposes unless no other less restrictive option is available to manage a current, serious, and ongoing threat to the safety of others,” and recommended that “[p]unitive segregation should be eliminated.”⁵⁷

71. Various faith-based organizations have issued similar policy statements and recommendations urging significant reductions in the use of solitary confinement and its outright elimination for some populations. For example, New York State Council of Churches passed a resolution in 2012 opposing the use of prison isolation and urging all members of the faith to participate in work to “significantly limit the use of solitary confinement.”⁵⁸ Similarly, that same year, the Rabbinical Assembly called

confinement or to eliminate its use altogether with prisoners who are mentally ill. For example, see, e.g., American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012), *available at* http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf (“Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.”); Mental Health America, Seclusion and Restraints, Policy Position Statement 24 (2011), *available at* <http://www.nmha.org/positions/seclusion-restraints> (“urg[ing] abolition of the use of seclusion . . . to control symptoms of mental illnesses”); National Alliance on Mental Illness, Public Policy Platform Section 9.8, *available at* http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38253 (“oppos[ing] the use of solitary confinement and equivalent forms of extended administrative segregation for persons with mental illnesses”); Society of Correctional Physicians, Position Statement, Restricted Housing of Mentally Ill Inmates (2013), *available at* <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates> (“acknowledg[ing] that prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment,” and recommending against holding these prisoners in segregated housing for more than four weeks).

⁵⁷ American Public Health Association, Solitary Confinement as a Public Health Issue, Policy No. 201310 (2013), *available at* <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1462>

⁵⁸ New York State Council of Churches, Resolution Opposing the Use of Prolonged Solitary Confinement in the Correctional Facilities of New York State and New York City

on prison authorities to end prolonged solitary confinement, and the solitary confinement of juveniles and of people with mental illness.⁵⁹

72. In fact, in recognition of the adverse mental health effects of segregated, solitary, or isolated confinement, the American Bar Association's Standards for Criminal Justice on the Treatment of Prisoners mandate that "[s]egregated housing should be for the briefest term and under the least restrictive conditions practicable."⁶⁰ Moreover, the ABA requires that the mental health of all prisoners in segregated housing "should be monitored" through a process that should include daily correctional staff logs "documenting prisoners' behavior," the presence of a "qualified mental health professional" inside each segregated housing unit "[s]everal times a week," weekly observations and conversations between isolated prisoners and qualified mental health professionals, and "[a]t least every [90 days], a qualified mental health professional should perform a comprehensive mental health assessment of each prisoner in segregated housing" (unless such assessment is specifically deemed unnecessary in light of prior individualized observations).⁶¹ In addition, at

(2012), available at <https://sites.google.com/site/nyscouncilofchurches/priorities/on-solitary-confinement>; Presbyterian Church (USA), Commissioners' Resolution 11-2, On Prolonged Solitary Confinement in U.S. Prisons (2012), available at [https://pc-biz.org/MeetingPapers/\(S\(em2ohn15h5sdehz2rjteqxtn\)\)/Explorer.aspx?id=4389](https://pc-biz.org/MeetingPapers/(S(em2ohn15h5sdehz2rjteqxtn))/Explorer.aspx?id=4389)

⁵⁹ Rabbinical Assembly, Resolution on Prison Conditions and Prisoner Isolation (2012), available at <http://www.rabbinicalassembly.org/story/resolution-prison-conditions-and-prisoner-isolation?tp=377>

⁶⁰ American Bar Association, ABA Criminal Justice Standards on the Treatment of Prisoners, Standard 23-2.6(a) (2010), available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoner_s.html [hereinafter "ABA Standards"].

⁶¹ ABA Standards, 23-2.8(b).

intervals “not to exceed [30 days], correctional authorities should meet and document an evaluation of each prisoner’s progress” in an evaluation that explicitly “should also consider the nature of the prisoner’s mental health,” and at intervals “not to exceed [90 days], a full classification review” should be conducted that addresses the prisoner’s “individualized plan” in segregation with “a presumption in favor of removing the prisoner from segregated housing.”⁶²

73. Moreover, just last year, the United Nations Crime Commission approved the Standard Minimum Rules for the Treatment of Prisoners (known as the “Mandela Rules”) that contained several provisions designed to significantly regulate and limit the use of solitary confinement. Specifically, Rule 43.1 prohibits the use of “indefinite” and “prolonged” solitary confinement, as well as the placement of prisoners in dark or constantly lit cells.”⁶³ More generally, Rule 45.1 provides that solitary confinement “shall be used only in exceptional cases as a last resort, for as short a time as possible...” and Rule 45.2 prohibits its use

⁶² ABA Standards, 23-2.9. See, also: New York Bar Association, Committee on Civil Rights Report to the House of Delegates: Solitary Confinement in New York State 1-2 Resolution (2013), available at <http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26699>, which called on state officials to significantly limit the use of solitary confinement, and recommended that solitary confinement for longer than 15 days be proscribed.

⁶³ Commission on Crime Prevention and Criminal Justice, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), United Nations Economic and Social Council, May 21, 2015. The Commission defined “solitary confinement” as “confinement of prisoners for 22 hours or more a day without meaningful human contact.” See Rule 44.

entirely “in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.”⁶⁴

74. Finally, in addition to prominent human rights, mental health, and legal organizations, distinguished expert panels that have investigated and analyzed these issues have reached similar conclusions. For example, in 2006, a landmark report was published that was based in large part on a series of fact-finding hearings conducted across the United States by the bipartisan Commission on Safety and Abuse in America’s Prisons. In the course of the hearings, diverse groups of nationally recognized experts, stakeholders, and policymakers testified about a wide range of prison-related issues. Among other things, the Commission concluded that solitary and “supermax”-type units were “expensive and soul destroying”⁶⁵ and recommended that prison systems “end conditions of isolation.”⁶⁶

75. The next year, in 2007, an international group of prominent mental health and correctional experts meeting on psychological trauma in Istanbul, Turkey issued a joint statement on “the use and effects of solitary confinement.” In what has come to be known as the “Istanbul Statement,” they acknowledged that the “central harmful feature” of

⁶⁴ Ibid.

⁶⁵ Gibbons, John, and Katzenbach, Nicholas. Confronting Confinement: A Report of the Commission on Safety and Abuse in America’s Prisons. New York: Vera Institute of Justice (2006), at p. 59, *available at* http://www.vera.org/sites/default/files/resources/downloads/Confronting_Confinement.pdf.

⁶⁶ *Id.* at p. 57.

solitary confinement is its reduction of meaningful social contact to a level “insufficient to sustain health and well being.”⁶⁷ Citing various statements, comments, and principles that had been previously issued by the United Nations—all recommending that the use of solitary confinement be carefully restricted or abolished altogether—the Istanbul group concluded that “[a]s a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort.” Notably, the specific recommendations they made about how such a regime should be structured and operated would, if adopted, end most forms of long-term isolated confinement.

76. In summary, the conclusion that long-term solitary or isolated confinement subjects prisoners to grave risk of serious psychological harm continues to be theoretically sound, has widespread and growing empirical support, and now reflects the overwhelming consensus view of human rights, mental health, and legal organizations as well as expert groups that have carefully considered the issue.

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

77. It is worth emphasizing that the widespread recognition of the painful and harmful mental and physical effects of prison isolation that I have summarized above has led to a consensus about three critically

⁶⁷ International Psychological Trauma Symposium, Istanbul Statement on the Use and Effects of Solitary Confinement, Istanbul, Turkey (December 9, 2007), *available at* http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf

important limits that must be applied to such confinement: 1) the time or duration that a person is exposed to solitary confinement must be minimized, 2) the risks of harm are so great that solitary confinement should be used only when it is absolutely necessary and as a last resort, and 3) the added risk of harm to vulnerable groups or individual prisoners means that they should be exempted entirely from prolonged solitary confinement.

78. Thus, virtually every mental health, legal, and human rights standard and set of recommendations concerning solitary confinement acknowledges that the risk of harm from isolation is time- or dose-dependent—that is, because the risks of psychological and physical damage increase as a function of the increased length of exposure, the use of solitary confinement should be limited to the briefest amount of time possible. In addition to those organizations that call for an outright ban on the use of solitary confinement because of its recognized harmful effects, below is a summary of just some of the recommendations that have been issued on time limits—limits that are typically measured in days and weeks (not years or decades, as in the present case):

—The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment wrote in 2011 that in his opinion solitary confinement lasting more than 15 days can constitute “torture”⁶⁸;

⁶⁸ Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, U.N. Doc A/66/268, ¶¶ 76-78 (Aug. 5, 2011).

—The American Bar Association’s 2010 Standards for Criminal Justice hold that “[s]egregated housing should be for the briefest term and under the least restrictive conditions practicable”⁶⁹ and that at intervals “not to exceed [90 days], a full classification review” should be conducted that addresses the prisoner’s “individualized plan” in segregation with “a presumption in favor of removing the prisoner from segregated housing”⁷⁰;

—The prominent mental health and correctional experts meeting on psychological trauma in 2007 in Istanbul, Turkey who issued the “Istanbul Statement” concluded that “[a]s a general principle solitary confinement should only be used... for as short a time as possible”⁷¹;

— The American Academy of Child and Adolescent Psychiatry’s 2012 policy statement on the solitary confinement of juveniles states that “any youth that is confined for more than 24 hours must be evaluated by a mental health professional”⁷²;

⁶⁹ American Bar Association, ABA Criminal Justice Standards on the Treatment of Prisoners, Standard 23-2.6(a) (2010), available at http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html [hereinafter “ABA Standards”].

⁷⁰ ABA Standards, 23-2.9 (emphases added).

⁷¹ International Psychological Trauma Symposium, Istanbul Statement on the Use and Effects of Solitary Confinement, Istanbul, Turkey (December 9, 2007), available at http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf.

⁷² American Academy of Child and Adolescent Psychiatry, Solitary Confinement of Juvenile Offenders (2012) (emphasis added), available at http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx

—The New York Bar Association in 2013 called on state officials to significantly limit the use of solitary confinement and recommended that solitary confinement for longer than 15 days be proscribed⁷³;

— The Society of Correctional Physicians concluded that segregating mentally ill prisoners on a “prolonged” basis lasting for more than four weeks should be prohibited⁷⁴;

—The American Psychiatric Association (APA) recommended in 2012 that “prolonged segregation” (which it defined as segregation lasting longer than four weeks) of prisoners with serious mental illness “with rare exceptions, should be avoided due to the potential for harm to such inmates;”⁷⁵

— And the United Nations Commission on Crime Prevention and Criminal Justice’s Standard Minimum Rules for the Treatment of Prisoners passed just last year defined “prolonged solitary confinement” as lasting “for a time period in excess of 15 consecutive days,” and mandated that such prolonged confinement “shall be prohibited.”⁷⁶

⁷³ New York Bar Association, Committee on Civil Rights Report to the House of Delegates: Solitary Confinement in New York State 1-2 Resolution (2013), available at <http://www.nysba.org/WorkArea/DownloadAsset.aspx?id=26699>. See also the Rabbinical Assembly, Resolution on Prison Conditions and Prisoner Isolation (2012), available at <http://www.rabbinicalassembly.org/story/resolution-prison-conditions-and-prisoner-isolation?tp=377>, which called on prison authorities to end prolonged solitary confinement.

⁷⁴ Society of Correctional Physicians, Position Statement, Restricted Housing of Mentally Ill Inmates (2013), available at <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates>.

⁷⁵ American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012), available at http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf.

⁷⁶ See Commission on Crime Prevention and Criminal Justice, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), United Nations Economic and Social Council, May 21, 2015, Rule 43.1 and Rule 44.

79. Many of these same organizations and agencies similarly emphasized that the grave risk of serious harm from solitary confinement require that it be used only upon a showing of absolute necessity. For example, the authors of the “Istanbul Statement” concluded that “[a]s a general principle solitary confinement should only be used in very exceptional cases... and only as a last resort,”⁷⁷ and the United Nations used almost identical language in formulating the “Mandela Rules” for the Treatment of Prisoners, mandating that solitary confinement “shall be used only in exceptional cases as a last resort.”⁷⁸

80. Moreover, expert, legal, and human rights organizations also have recommended that, because of the increased grave risk of serious harm to which solitary confinement exposes them, vulnerable prisoners should be exempted from any form of prolonged placement. Thus, as I noted earlier, the American Psychiatric Association (APA) has recommended that “prolonged segregation” of prisoners with serious mental illness “with rare exceptions, should be avoided due to the potential for harm to such inmates,”⁷⁹ and United Nations Standard Minimum Rules for the Treatment of Prisoners, Rule 45.2, prohibits its

⁷⁷ International Psychological Trauma Symposium, Istanbul Statement on the Use and Effects of Solitary Confinement. Istanbul, Turkey (December 9, 2007), *available at* http://www.univie.ac.at/bimtor/dateien/topic8_istanbul_statement_effects_solconfinment.pdf.

⁷⁸ Commission on Crime Prevention and Criminal Justice, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), United Nations Economic and Social Council, May 21, 2015, Rule 45.1.

⁷⁹ American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2012), *available at* http://www.psych.org/File%20Library/Learn/Archives/ps2012_PrisonerSegregation.pdf.

use entirely “in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.”⁸⁰

81. As I will discuss in the remainder of this Declaration, all three of these consensus positions appear to have been violated. He has been kept in isolated confinement for three-and-a-half decades, many orders of magnitude beyond any of the tolerable or acceptable maximum limits envisioned in any of the guidelines or principles that have been promulgated. Moreover, he has been kept there despite a decades-long history of conforming behavior. As I will discuss below, there is no plausible justification offered anywhere in Mr. Johnson’s file that his continued isolation is “necessary” to achieve any legitimate penological goal or interest. And, finally, again, as I will discuss below, his advancing age and the cumulative effects of such an extraordinary length of time spent in isolation, absorbing its adverse psychological stressor and pains, have begun to take a serious toll on him. His increased vulnerability provides another compelling argument for expediting his release from isolation.

⁸⁰ See Commission on Crime Prevention and Criminal Justice, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), United Nations Economic and Social Council, May 21, 2015, Rule 45.2. See, also: American Academy of Child and Adolescent Psychiatry, Solitary Confinement of Juvenile Offenders (2012), available at http://www.aacap.org/AACAP/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders.aspx, which opposes “the use of solitary confinement in correctional facilities for juveniles”; Mental Health America, Seclusion and Restraints, Policy Position Statement 24 (2011), available at <http://www.nmha.org/positions/seclusion-restraints>, “urg[ing] abolition of the use of seclusion . . . to control symptoms of mental illnesses”; and the National Alliance on Mental Illness, Public Policy Platform Section 9.8, available at http://www.nami.org/Template.cfm?Section=NAMI_Policy_Platform&Template=/ContentManagement/ContentDisplay.cfm&ContentID=38253, “oppos[ing] the use of solitary confinement and equivalent forms of extended administrative segregation for persons with mental illnesses.”

V. ARTHUR JOHNSON'S CONDITIONS OF CONFINEMENT AND INSTITUTIONAL HISTORY

82. The above scientific, correctional, and human rights consensus provides the context or backdrop against which Arthur Johnson's extraordinarily long period of isolated confinement should be evaluated. As I have outlined in great detail above, there is a substantial body of scientific data to support the proposition that depriving human beings of normal social contact is psychologically dangerous and harmful. There is a widespread professional, legal, correctional, and human rights consensus to significantly limit its use, only under circumstances where it is absolutely necessary and for the shortest possible amount of time, and precluding its use entirely for certain categories of vulnerable prisoners.

83. A prisoner's psychological reactions to isolated confinement are shaped at least in part not only by the nature, severity, and duration of the isolation, but the psychological make-up and potential vulnerabilities of the prisoner himself. Ordinarily, pre-existing psychological problems and issues can play a role in understanding why and how some people react especially badly to isolation and others less so. In Mr. Johnson's case, the customary psychological background materials were not included in his prison file. I relied instead on Mr. Johnson's own brief description of his life before he came into the Pennsylvania Department of Corrections (DOC), while still in his teenage years. Also, because the DOC records I reviewed began in 2003, my account and understanding of Mr. Johnson's years in isolated confinement before that time are based in large part on my personal interview with him.

84. In my interview with Mr. Johnson, although he was quiet and reserved at first, he became increasingly comfortable as we spoke. He

was candid and forthcoming in answering all of the questions I posed to him.

85. Mr. Johnson told me that he grew up in a tough neighborhood in Philadelphia that was plagued by a great deal of crime. His mother passed away when he was only two years old, and he has no memories of her. His paternal grandmother, aunts, and father (who never remarried) raised him. Mr. Johnson told me that had a troubled childhood from his early school years on, and that he spent a lot of time in juvenile justice facilities.

86. Mr. Johnson was only 18 years old when he was given a life sentence for murder. He said he had a very difficult time accepting that he would spend the rest of his life in prison. Mr. Johnson said that his inability to come to terms with that harsh fact led to many early disciplinary infractions in DOC, including being place in “the hole” on a number of occasions. He also felt that lessons he had learned as a kid on the streets in his neighborhood in Philadelphia—that you have to “fight back” and that “you can either be weak and break or be strong and fight”—had perhaps served him well there, but caused him a great deal of trouble in the prison system.

A. The Conditions of Isolated Confinement to Which Arthur Johnson Has Been Exposed

87. Mr. Johnson reported that he spent time in various disciplinary segregation units⁸¹—called “Behavioral Adjustment Units”

⁸¹ As I made clear earlier, there is little question that the conditions of confinement in the Pennsylvania DOC to which Mr. Johnson had been subjected constitute “isolation” or “solitary confinement.” In addition to my own independent opinion on this fact, note that the United States Department of Justice concluded exactly the same thing in direct communications with the Pennsylvania DOC. See Letter from Jocelyn Samuels and David

(BAUs) and later renamed “Restricted Housing Units” (RHUs) before the serious incident in 1979 at SCI Pittsburgh that resulted in his continuous isolation since then. Mr. Johnson said that once the attempted escape and hostage taking at SCI Pittsburgh occurred, he believes that he was placed in the worst isolation units throughout the state prison system, with no possible way of earning his way out. The harshness of the conditions is beyond dispute. In addition to my own observations of these conditions, I note that in 2014 the United States Department of Justice found that the DOC’s isolation units to be “unjustifiably harsh.”⁸²

88. Below is the description of these normatively harsh conditions of isolated confinement in the DOC that the Justice Department provided and that are, again, entirely consistent with my own direct observations and understanding, and corroborated in my interview with Mr. Johnson:

...Every prisoner placed in solitary confinement must spend almost his entire day confined to a cell that is less than 100 square feet in size--about the size of an average American bathroom. The cell contains a metal bed frame, a thin plastic mattress, metal sink, metal toilet, and metal desk with an attached metal seat, and sometimes a small shelf. At some of the prisons, the cell will also have a small exterior-facing window, but at many of the prisons, the cell has no exterior window and no natural light coming directly into it. Usually, the prisoner

Hicks to Governor Tom Corbett, on the Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities, U.S. Department of Justice, Civil Rights Division, February 24, 2014. Having defined isolation or solitary confinement as “the state of being confined in one’s cell for approximately 23 hours per day or more,” and “solitary confinement unit” or “isolation unit” as “a unit where either all or most of those housed in the unit are subjected to solitary confinement,” (id. at p. 4), the Department recognized that RHUs, like the ones Mr. Johnson has been confined in for decades, constitute solitary confinement because “[p]risoners in the RHUs are usually confined to their cells for roughly 23 hours a day” (id. at p. 5)

⁸² For example, id. at p. 9.

is locked in his cell behind a solid metal door. The door has a narrow slot (used for passing food trays and for handcuffing the prisoner before he can leave the cell), and a small plastic window with a view to either a hallway or the housing unit's common area.

The lighting in the cell can be dimmed, but it can never be turned off, even at night. The noise level can be high, even at night, because of the yelling and banging of neighboring prisoners. The prisoner with SMI in solitary confinement in PDOC has limited out-of-cell time. Typically, he is allowed, at most, one hour in an empty and caged outdoor pen, five times a week, and a 15-minute shower three times a week...

Before he can leave his cell, a prisoner must first submit to a strip search. Further, to get from his cell to an out-of-cell activity, the prisoner is at all times escorted by correctional officers and has his arms and legs shackled together. Many prisoners we spoke to told us that they rarely leave their cells because of these procedures. They explained that being strip searched, handcuffed, and led by tether by two corrections officers made them feel like animals.

... disciplinary custody at an RHU generally has no access to television or radio; has only limited access to reading materials; cannot make telephone calls (with the exception of emergency calls approved by management); is denied contact visitation privileges; is denied any opportunity to have non-contact visits with friends; and, at most, can only have one non-contact visit per month with an immediate family member, lasting for no longer than an hour.

Living conditions in the RHU routinely involve a mix of disorienting and uncomfortable sensory experiences. For example, the air quality is often poor because of inadequate sanitation and ventilation. At one of the solitary confinement units we visited where the sanitation was especially bad, prisoners complained *en masse* to us about the smell of the place. A prisoner there explained, "The smell is terrible. When a prisoner smears feces on the walls, it's often left like that for days and the entire pod reeks of shit and makes you want to vomit."⁸³

⁸³ Id. at p. 9-10, footnote omitted.

89. Although the focus of the Justice Department’s investigation was on the effects of these conditions on seriously mentally ill prisoners, it is important to recognize that the harsh conditions they observed were experienced by every prisoner who, like Arthur Johnson, was housed in Pennsylvania’s RHUs. Moreover, the lengths of time in solitary confinement that the Justice Department representatives correctly characterized as “long-term” and “prolonged” in the Pennsylvania prison system and about which they justifiably complained (citing, for example, the number of mentally ill prisoners who had been kept in RHUs for a year or more) pale in comparison to the more than three-and-a-half decades of confinement that Mr. Johnson has experienced in many of these same facilities.⁸⁴

90. In addition, the painfulness of Mr. Johnson’s isolated confinement was exacerbated not only by the harshness of the conditions and the extraordinary length of time that he has been subjected to them but also because he became convinced that he was helpless to alleviate this suffering. More specifically, he told me that he does not know, and has never been told, what steps he could or should take to bring about an end to his painful isolation. His claim that DOC officials have been unresponsive to his requests to be released from isolation and have failed

⁸⁴ The understanding that conditions of confinement that do not otherwise constitute cruel and unusual punishment could become so if experienced for lengthy periods of time is longstanding. For example, see *Madrid v. Gomez*, 889 F. Supp. 1146 (1995). It was actually recognized with respect to the Pennsylvania prison system, at around the time Mr. Johnson was beginning his long odyssey in the state’s solitary confinement units. In *Imprisoned Citizens United*, the court described conditions in a special “Glass Cage” unit at SCI Huntingdon—one that Mr. Johnson reported to me that he actually was housed several times—as “harsh” and “bleak.” Although the court did not declare these this unit unconstitutional per se, it also explicitly acknowledged that “conditions that would be permissible if for a short time may become cruel and unusual if lengthy” *Imprisoned Citizens United v. Shapp*, 461 F. Supp. 522, 526 (1978).

to provide him with meaningful guidance about what he can do to facilitate his return to general population is amply supported by the DOC records that I reviewed.

B. Arthur Johnson's Pennsylvania DOC File Since 2003

91. The portion of DOC file I was provided and reviewed contain official documents that have been placed there since 2003, covering the most recent approximately 13 years that Mr. Johnson has been kept in isolated confinement. I will discuss them in two separate sections—Mr. Johnson's custody and classification records and the record of his mental health contacts during this period.

1) Mr. Johnson's Custody and Classification Records in the DOC

92. The portion of Mr. Johnson's file that I was provided includes, among other things, the various grievances that he has lodged with the prison administration over the years addressing different aspects of his confinement. They reveal him to be conscientious and respectful. His complaints focus on basic aspects of his confinement—access to yard, charges made against his inmate account, not getting his commissary orders delivered, but are unremarkable and appropriate in nature. Similarly, the reports of his "general appearance and behavior" during, for example, his routine medical examinations over the many years he was confined in isolation describe him uniformly as "calm," "cooperative," "normal," and "appropriate." There is no indication that, during the

decade-long period covered by the records, Mr. Johnson was in anyway a troublesome, disruptive, or disrespectful prisoner who created or presented any custody-related problems for staff.

93. In addition to the grievances he filed over aspects of living conditions, there are a number of “inmate request to staff member” and other forms that convey Mr. Johnson’s repeated requests to be removed from RHU and placed back in general population (e.g., on June 19, 2009, to the Superintendent at SCI Forest). There are numerous indications that also he has made this request verbally, on many occasions, to relevant staff and committees (e.g., on January 16, 2003, April 10, 2003, at SCI Greene; on June 15, 2006, May 17, 2007, August 9, 2007, January 24, 2008, and June 11, 2009 at SCI Forest; on December 15, 2010 and November 10, 2011, at SCI Rockview).

94. However, based on the files I reviewed, there do not appear to be any meaningful, substantive responses from Pennsylvania DOC officials to Mr. Johnson’s numerous requests to be released from isolated confinement. Instead, the DOC uses the same uninformative, boilerplate language is used purporting to justify his decades-long solitary confinement, seemingly entirely on the basis of events that occurred in 1979, for which the absence of any supporting documentation is repeatedly acknowledged. This continues to occur despite Mr. Johnson’s record of consistently conforming behavior—behavior that is repeatedly described as either “good” or “satisfactory” or “acceptable” or “doing well”⁸⁵—while

⁸⁵ In addition to the entries mentioned in various paragraphs in the body of this Declaration, the unit reports that I reviewed continuously describe Mr. Johnson’s behavior as “satisfactory” (for example, his behavior is characterized this way on July 3, 2003 and October 2, 2003, at SCI Greene, on May 20, 2004 at SCI Rockview), and on December 2, 2004 at SCI Smithfield), as “acceptable” (for example, at SCI Smithfield, on October 7, 2004 and November 4, 2004), and he is characterized as “doing well” (on February 3, 2005 at SCI Forest). These positive comments continue to through the most

he is being subjected to truly severe conditions of confinement. I review this part of his record in some detail in the following paragraphs because it adds the important dimensions of unresponsiveness and uncontrollability to Mr. Johnson's extraordinarily long period of isolated confinement, dimensions that exacerbate the psychological damage resulting from his experience.

95. The custody and classification records that I was provided begin mid-year, 2004, after Mr. Johnson had already be held in isolation for a quarter century, and end in July, 2015. The records indicate that on June 8, 2004, Mr. Johnson was placed in the RHU at SCI Smithfield. This placement was said to be "due" to his transfer from SCI Rockview while on AC status. The report of the "Program Committee's Decision and Its Rationale" dated July 15, 2004 indicated that the Committee's decision to transfer him to the LTSU ["Long Term Segregation Unit"] was based on his "extensive, disruptive history during his incarceration." Yet the same report acknowledged that "RHU officers report no concerns" about Mr. Johnson, his "adjustment in the RHU is described as good," and he was said to be "quiet and cooperative with staff." Essentially the same rationale for his continued isolation was repeated a month later, when the Program Review Committee met on August 12, 2004, despite the same positive characterizations of Mr. Johnson's behavior.

96. The records reflect that a few months later, on February 4, 2005, SCI Smithfield Superintendent Sobina informed Mr. Johnson that he was being retained on "A.C. status" because of his "poor overall

recent time period covered by the available records. For example, on June 3, 2015, he "[g]ood housing reports are noted." In the most recent years, the PRC "encourages" Mr. Johnson to "stay misconduct free and to earn good housing reports" (e.g., December 11, 2014), which he invariably does, but to no avail.

adjustment” at his previous institution, and that his isolated confinement would not be changed “until a successful adjustment to general population appears likely.” However, no evidence of “poor overall adjustment” at Mr. Johnson’s previous institution (SCI Rockview) was cited, and no guidance was provided with respect to exactly what behavior—other than the conforming behavior in which he had been engaged—would make “a successful adjustment to general population appear likely.” In fact, the succession of subsequent communications that Mr. Johnson received from various Program Review Committees suggested that his behavior was irrelevant to his retention in isolation, and that he was utterly powerless to change that fact.

97. Thus, after Mr. Johnson was transferred to RHU at SCI Forest on January 25, 2005, he personally appeared before the Program Review Committee on the next day. A report of the Committee’s conclusions was filed on February 3, 2005, in which it was noted that Mr. Johnson was “polite and cordial.” But the Committee made no recommendation about releasing him from isolation. The next documented “Committee Decision and Rationale” was filed a few months later, on April 19, 2005. Mr. Johnson’s adjustment was again described as “satisfactory “ and “no major issues or concerns” were noted. The report acknowledged that Mr. Johnson complained that “he was being moved once every 10 or 11 days as opposed to once per month”—suggesting that he was not only being retained in isolation but that he also was being subjected to enhanced security procedures.

98. The written justification given for his continued placement in Administrative Custody, stated in this April, 2005 report, was: “the inmate is a danger to some person(s) in the institution who cannot be protected by

alternative measures. Specifically, he is a long-term AC status inmate with an assaultive history.” The “danger” Mr. Johnson supposedly represented was described in entirely non-specific terms—referencing only “some person(s)” —and the nature of the danger appeared to be based on his status as a “long-term AC inmate.” However, the only justification offered for this status was Mr. Johnson’s “problematic history.” Thus the “threat” he supposedly represented to “some person(s)” was based on his AC status, and his AC status was based on his “history”—a distant and remote history that he could not change.

99. A few months later, the rationale for Mr. Johnson’s continued isolation appeared to have changed slightly. Thus, the Program Review Committee’s report filed on July 14, 2005 indicated that Mr. Johnson “continues to request placement in general population.” Again, however, his RHU housing was justified on the basis of “a problematic history.” But this time the reasoning had shifted: “[I]nmate Johnson will be continued in Administrative Custody because placement in the general population would endanger the inmate’s safety or welfare when it is not possible to protect him by other means.” Clearly, now, the alleged “danger” that Mr. Johnson supposedly once represented to others had been transformed into a danger others represented to him. Once again, no more specific information was provided and no explanation of this shift in rationale was given.

100. In October 6, 2005, the two previous justifications were asserted together, in the same document, with no attempt made to explain what had changed. Thus the Program Review Committee indicated that, although Mr. Johnson’s behavior in the RHU continued to be “acceptable,” he was retained in isolation both because “[t]he case file indicates he

remains a threat to our population” and “placement in general population would endanger [his] safety or welfare.” Again, no documentation was provided that specified or explained why he represented a threat, or to whom, or why his safety or welfare were in danger, or from whom.

101. On December 29, 2005, Mr. Johnson continued to be described as having demonstrated “satisfactory” behavior and “officers report he remains quiet on the unit.” The threat to his safety that had supposedly existed if he were to be placed in the SCI Forest population had now somehow disappeared but Committee continued to assert that Mr. Johnson posed “a danger to some person(s) in the institution.” Neither the nature of the danger nor the identity of the persons was specified.

102. By March 23, 2006, these rationales had been garbled together into an explanation for continued isolated confinement that I honestly cannot decipher. Specifically, the Program Review Committee’s justification for keeping Mr. Johnson in isolation was expressed this way: “the inmate is a danger by/from some person(s) in the institution who cannot be protected by alternative measures.” I have reproduced that last sentence verbatim but I confess that I do not know exactly what it means. Nonetheless, this same sentence is repeated as the rationale for Mr. Johnson’s continued confinement in isolation in Program Review Committee reports filed at SCI Forest on June 15, 2006, September 7, 2006, November 30, 2006, February 22, 2007, May 17, 2007, August 9, 2007, November 1, 2007, and January 24, 2008.

103. When Mr. Johnson appeared before the Program Review Committee in April, 2008, he again “requested to be released to population. This time, the April 17, 2008 report explained simply, but no more informatively, that “he would not be released to population due to

his history...” This new justification essentially codified what had been implied all along; omitting any reference to Mr. Johnson allegedly being a danger to others, or being in danger himself, it simply justified his continued isolation on the basis of something he clearly could not change, “history.”

104. The same rationale was included in the next Program Review Committee report, dated July 10, 2008. When Mr. Johnson requested release to the general population, his request was denied, and only the now familiar “problematic history including assaultive behavior” cited as the reason. Here, too, this reason was used despite the fact that Mr. Johnson was described as having been “quiet in the RHU.” This rationale and description of his conforming behavior was repeated in the October 2, 2008 review. The same rationale was used in the December 24, 2008 report, except that the previously uninterpretable language now reappeared: “the inmate is a danger by/from some person(s) in the institution who cannot be protected by alternative measures.” It was repeated verbatim in subsequent SCI Forest Program Review Committee Progress reports, on March 19, 2009 and June 11, 2009.

105. On September 3, 2009, at SCI Forest, a Program Review Committee Action report was filed. It indicated that, at that time, Mr. Johnson had been in “Continuous Security Level 5 Housing” for 29 years 8+ months. The report indicated that Mr. Johnson asked the Committee “why he was placed back on the Restricted Release List,” and he reminded them that “he has never been a problem here.” He further told the Committee he felt he had “paid for what he has done” and was “being punished over and over for the things he did in the past.” In response, the Committee simply repeated the same boilerplate, uninterpretable

language that had been used in the past: his “problematic history” meant he was “a risk to the security of the institution,” and that he was “a danger by/from some person(s) in the institution who cannot be protected by alternative measures.”

106. Mr. Johnson was transferred to SCI Huntingdon in late 2009. He appeared at his first Program Review Committee on December 2, 2009. A document containing the “Program Review Committee’s Decision and Its Rationale,” dated that same day at SCI Huntingdon indicated that Mr. Johnson was “to be here short term.” Although he had originally been placed in Restricted Housing “due to a Misconduct” in 12-22-1979 (some 30 years earlier), the report also noted that “[r]ecords specific to the reason were not available.” Remarkably, although the document mentioned a “problematic past with assaults and escape attempts, it also acknowledged that ”Mr. Johnson’s “adjustment within the RHU” was “satisfactory since 4-22-99,” approximately 10 years from the time of the review, and that the “RHU officers report no new concerns.” Nonetheless, he was retained in isolated confinement.

107. Another ultimately uninformative and unresponsive statement of the “Program Review Committee’s Decision and Its Rationale,” was completed at SCI Huntingdon a few months later, on January 13, 2010, just before Mr. Johnson was transferred to another institution. It repeated a boilerplate rationale for his continued isolation, noting that “[t]here are numerous security concerns related to this case,” and repeated the same exact phrase in the next paragraph (“there are numerous security concerns related to this case”). Rather than explaining what those concerns were, the review “rationale” acknowledged that the “[r]ecords specific to the reason” for Mr. Johnson’s 12/22/1979 placement

in Restricted Housing more than 30 years earlier “were not available.” The Committee report then re-introduced a rationale for Mr. Johnson’s isolated confinement that had not been employed for years: “the inmate is a danger to himself or others.” It did not include an explanation of the basis for this renewed claim, one made all the more questionable by the fact that the review report also acknowledged—as virtually all of the numerous, preceding ones had—that Mr. Johnson’s RHU adjustment had been “satisfactory,” and that “the RHU officers report no concerns this review period.”

108. On January 22, 2010, Mr. Johnson was transferred from SCI Huntingdon to SCI Rockview. He had his Administrative Custody/802 review there on February 4th of that year (although I could find no documentation of what transpired). On September 23, 2010, December 15, 2010, March 3, 2011, May 26, 2011, August 18, 2011, November 11, 2011, February 2, 2012, April 26, 2012, July 19, 2012, and again on October 11, 2012, Mr. Johnson’s administrative custody was reviewed at SCI Rockview. Each time the corresponding reports acknowledged that, although Mr. Johnson had been kept in Restrictive Housing since 12/22/79 “due to a misconduct,” the “[r]ecords specific to the reason are not available.” The most specific explanation was provided on January 3, 2013, when Mr. Johnson was still at SCI Rockview. He was described as having been “in Restrictive Housing Unit on DC or AC status since 12/22/79”—some 34 years of isolation—“largely due to misconducts related to Escape attempts and/or possession of implements of Escape.” Those were the “misconducts” for which “[r]ecords specific to the reason” continued to be “unavailable.” And, if those misconducts were now only

“largely” the reason for keeping him for nearly three-and-a-half decades in isolation, nothing in addition was provided in the report.

109. In early 2013, Mr. Johnson was transferred from Rockview to SCI Frackville. On February 28, 2013, a Program Review Committee’s Decision and Rationale report described Mr. Johnson as having been received at SCI Frackville from SCI Rockview as an “ADM/SEP transfer.” He was placed in the RHU Annex at Frackville, and his request to have a TV was denied by the Superintendent, even though “[h]is adjustment within the RHU is described as satisfactory” and the “RHU officers report no concerns this review period.” On May 30, 2013, at SCI Frackville, Mr. Johnson had a “privileges review” in which he was described as having continued to show “positive adjustment.” He was given a TV, a digital antenna, and sneakers, but he nonetheless was retained in “long term AC” due to his unchanged Restricted Release List status.

110. In recent years, Mr. Johnson has been nearly disciplinary free and has received no serious write-ups of any kind—for many years. Most recently, Mr. Johnson was written up in March, 2013, for what seems like more of a misunderstanding, rather than even a minor disciplinary infraction. Mr. Johnson appears to have had a multi-vitamin given to him on his way to the yard by a nurse.⁸⁶ He then took it back to his cell so that he could take it with fruit (because, he said, probably correctly, that vitamins are best taken with food) and, when the officer discovered the multi-vitamin in his pant leg, he was written up for contraband. There was no allegation that the pill was anything other than a vitamin or that Mr. Johnson was not entitled to possess it, only that he was not supposed to

⁸⁶ Note that Mr. Johnson’s concerns about access to vitamins were reflected in his file as early as September 9, 2004, when he inquired about them at a Program Review Committee meeting.

bring it back from yard. It should be noted that the records reflect that, prior to this minor infraction, “[h]e was 15 years free of misconducts...” (Program Review Committee’s Decision and Rationale, September 12, 2013).

111. Despite this, Mr. Johnson continues to request clarification over his continued placement in isolation and guidance about what he can do to arrange for his release, and fails to get meaningful responses to either request. His August 13, 2014 correspondence with DOC Eastern Region Staff Assistant Scott Miller is illustrative of the uninformative responses that he continues to receive. Mr. Miller contended that Mr. Johnson had, in fact, repeatedly been given an explanation for his continued placement in isolation—that it was “due to serious escape history”—which presumably refers to events that occurred in 1979, some 35 years before. In response to Mr. Johnson’s request for guidance about what he could do to facilitate his release, Mr. Miller offered this “advice”: “I would encourage you to demonstrate positive behavior and to work with staff in a constructive manner.” However, that is precisely what Mr. Johnson has been doing, for decades, and continues to do to the present day. He remains in isolation.

2) Mr. Johnson’s Mental Health Records in the DOC

112. The “mental health records” that I was provided pertaining Mr. Johnson’s time in prison date from April, 2003, after he already had been in isolation for some 24 years, and ended in 2013. They are pro forma and largely uninformative, devoid of any kind of in-depth psychological analysis or insights concerning either Mr. Johnson’s mental health or the

effects of extremely harsh and psychologically damaging isolation to which he has been subjected for decades. Instead, the mental health entries and observations are superficial, often boilerplate and repetitive, and typically reflect little more than endorsements of corrections-based (rather than psychologically-informed) judgments and recommendations that rely entirely on Mr. Johnson's earlier disciplinary history rather than his current psychological make-up, emotional state, and overall functioning.

113. Thus, for example, Mr. Johnson's prison file contains a number of "Suicide Risk Indicators Checklists," all of which appear to have been filled out by correctional officers or correctional lieutenants. They consist of no more than superficial observations (e.g., "inmate seems OK," and "no suicidal ideation"). The most detailed, but still uninformative, of the checklists in the file I reviewed include entries such as this: "Inmate seen at cell door. Inmate denied suicidal and/or homicidal ideation. Inmate instructed to report any changes to staff."

114. The Pennsylvania DOC's heavy reliance on "cell front" contacts by correctional officers and mental health staff as the primary means of routinely monitoring the mental health of isolated prisoners like Mr. Johnson is problematic for several reasons. Of course, correctional officers are not trained mental health professionals. Moreover, even when mental health staff conduct them, cell front contacts typically reveal only the most extreme and clearly visible forms of psychological distress and deterioration. Because isolated prisoners do not actually "do" much, there are few opportunities to notice unusual behavior or changed patterns of interacting. Thus, cell front monitoring places the onus on prisoners to volunteer their own symptoms or signs of dysfunction, something they may be unwilling or unable to do. In addition, prisoners in general and

isolated prisoners in particular almost never talk about psychological problems with custody staff. They rarely do so with mental health staff if the contacts are cell-front. This is because they do not want to reveal sensitive information to staff within earshot of other prisoners. Finally, “instructing” prisoners to share “suicidal and/or homicidal ideation” with staff—part of the DOC “Suicide Risk Indicators Checklists” protocol—is a similarly ineffective safeguard. It first sets the bar for distress or deterioration very high (suicidal and/or homicidal ideation), places responsibility for “self-diagnosis” on the prisoners, and instructs them to do something (report changes in their mental state to staff) that most of them are adamantly opposed to ever doing.⁸⁷

115. In addition to the Suicide Risk Indicators Checklists, there were other kinds of documents in Mr. Johnson’s file that purported to address his mental health. Unfortunately, they were only marginally more informative. For example, a “Cumulative Adjustment Record,” filled out at SCI Greene on April 1, 2003, based on another cell front contact (this time with mental health staff), described Mr. Johnson as “submissive.” It noted only that he did not report any “psych/health/MH issues or concerns” and that he “appeared to be in stable condition,” but was no more probative of his underlying mental health or state of mind.

116. Another seemingly more meaningful but still hardly in-depth contact occurred on May 12, 2003, when the results of what was described

⁸⁷ The inadequacy of “cell-front” psychological evaluations of was underscored by a former DOC staff psychologist who was quoted in the Justice Department report: “One former staff psychologist explained that he found it difficult to appropriately assess the condition of prisoners in solitary confinement. He emphasized that his manager discouraged him from doing anything other than cursory cell-side assessments of prisoners’ mental health. He noted that for inmates who were inactive and in their cells most of the time, it was next to impossible to fully assess the condition of prisoners from cell-side without an out-of-cell visit.” At p. 9.

as a “normal psychological interview” were recorded. Mr. Johnson was described as “unclean & not well organized.” The mental health staff worker noted that Mr. Johnson “refused to talk much” but that “[i]t appeared he still has to make adjustments”—although, after some 34 years of isolation, it was not clear what he was still adjusting to. He was described as being “[e]motionally labile” and, somewhat inconsistently, as having “flat affect.” The staff worker recommended that Mr. Johnson “be checked into but not necessarily often.” A little more than a month later, however, another mental health worker saw him cell front and said he “seemed to be doing well.” There was no evidence of any meaningful follow-up examination in conjunction with the emotional lability and flatness of affect observed earlier.

117. This seemed to establish a pattern that persisted for the next decade—Mr. Johnson is seen cell front and primarily only at cell front, admits to or volunteers no mental health problems or concerns, and the mental health worker duly records that he is just fine. This exact pattern is documented, for example, on September 29, 2003, March 22, 2004, July 2, 2004, October 14, 2004, June 20, 2005, November 17, 2005, December 28, 2005, March 22, 2006, June 12, 2006, November 30, 2006, January 4, 2007, February 20, 2007, May 16, 2007, August 7, 2007, October 31, 2007, January 23, 2008, April 17, 2008, July 9, 2008, September 30, 2008, December 23, 2008, March 16, 2009, June 10, 2009, September 2, 2009, January 5, 2010, July 5, 2010, June 17, 2013, July 29, 2013, April 15, 2015, May 19, 2015, May 27, 2015, June 3, 2015, June 22, 2015, and July 10, 2015.

118. As a result, with few exceptions, the “mental health file” covering Mr. Johnson’s 13 years of isolated confinement contains

numerous “mental health contact notes,” at first spaced at roughly 90-day intervals (although I cannot account for the three year gap between July, 2010 and July, 2013), and then more frequently in 2014 and 2015, that nonetheless provide no meaningful mental health assessments of, or clinical insights into, Mr. Johnson or reflect any appreciation of the adverse psychological effects of the extraordinarily long-term isolated confinement to which he has been subjected. Each report contains basically the same uninformative descriptive account, based on superficial cell-front contact: “inmate voiced no concerns,” and “[n]o psychological preclusions exist to continued housing in RHU at the time of this report.” Interestingly, however, beginning on April 17, 2008 and continuing through September 2, 2009 (with exception of June 10, 2009), the boilerplate language was changed to include this option: “there is no acute psychopathology apparent that would preclude inmate’s release from or continued stay in, the RHU at this time.” No reason was provided for the introduction of the new phrase into the mental health staff’s conclusions, or why it reverted to the previous boilerplate (omitting mention of his possible release to general population) after September 2009.

119. The few exceptions to these entirely superficial and uninformative “mental health contact notes” entries in Mr. Johnson’s file occurred sporadically and infrequently, at several year intervals. They are part of what is apparently supposed to be the DOC’s annual review of isolated prisoners’ suitability for continued housing in solitary confinement-type conditions. Although somewhat more detailed than the “mental health contact notes,” and apparently based on out-of-cell interviews (rather than exclusively cell-front contacts), they still do not remotely represent in-depth psychological evaluations, assessments, or

analyses. Nor do they appear to reflect any real understanding of the significant risk of serious psychological harm that isolated confinement represents.

120. The first one of these evaluations in the file that I reviewed was actually appended to another report. It was entitled a Report of Restricted Housing Unit (RHU) Evaluation, and dated May 3, 2001.⁸⁸ It noted that Mr. Johnson, who was then in his 32nd year of isolation, had appeared for a clinical interview but had refused to submit to personality testing. Instead, the clinician—presumably, David Sacks, a psychological services specialist (with unspecified advanced training or education and no advanced degree indicated) relied on personality testing that been completed six years before (in 1995). Although Mr. Sacks had ignored the implications of that earlier testing, it did identify several areas of potential concern for a prisoner who was being evaluated for suitability for continued isolated confinement. Those areas of concern included the fact that the testing revealed that Mr. Johnson had a “very low tolerance for frustration” (a psychological reaction that is significantly worsened and can become very problematic for prisoners in isolation), a tendency to “exhibit periods of increased irritability” (also something that is greatly exacerbated for most people housed in these units), and a susceptibility to suffer “periods of significant depression” (again, a clinical pattern that is very common, and dangerous, in isolated confinement, where rates of suicide are much greater than elsewhere in the prison system).

⁸⁸ The authorship of this report is somewhat confusing. Although it is signed by “Psychological Services Specialist” Sacks, it makes a number of references to another, 1995 report, authored by PSA D. Sacks,” referenced in the third person. Presumably, the author of both the 1995 and 2001 evaluations are the same person.

121. The evaluator (presumably, Mr. Sacks) was either unaware of these risks or chose to ignore them. Instead, he relied on what he described as Mr. Johnson's "record of long term positive adjustment to the RHU" to conclude that he had "adapted well to his current circumstances." However, Mr. Sacks did note that, although he felt there were "no clinical contraindications to [Mr. Johnson's] continued AC status," there also were no clinical reasons "to preclude his release to General population, either."

122. In the final analysis, Mr. Sacks reached a fundamentally correctional rather than psychological judgment. That is, without offering any psychological rationale or basis for doing so, he concluded that Mr. Johnson represented "a great risk to the safe and orderly running of the institution." Similarly, his final recommendation—that Mr. Johnson "continue to be maintained on AC status in the RHU in order to minimize any possible institutional disruption"—appeared to be based on correctional rather than any psychological considerations.

123. Another rare out-of-cell evaluation of Mr. Johnson occurred several years later, on August 30, 2004, when a "Confidential Psychological Evaluation for Long-Term Segregation Unit Consideration" was conducted at SCI Smithfield. Mr. Johnson was taken to the "interview room of the Restricted Housing Unit" where he was described as "cooperative," "polite," and willing to answer all of the questions posed to him. Although the evaluation appears to have been conducted entirely by an M.A.-level "psychological services specialist"—Debra Houck—it contained very little in the way of psychological insight or analysis. Instead, Ms. Houck merely noted that Mr. Johnson "denies any past suicide and has not taken medication for any psychiatric disorders." In fact, she, too, concluded with a correctional—not psychological—opinion,

namely that “[t]he highly structured environment of an LTSU would be appropriate for this inmate.”⁸⁹ There are no psychological factors or considerations cited in the evaluation that would support this conclusion, and no attempt whatsoever, even in passing, made to grapple with the adverse psychological consequences of continuing to keep Mr. Johnson in isolated confinement for 35 years or more.

124. The report of the next such evaluation was filed on January 3, 2006, at SCI Forest, and was entitled a “Psychological Evaluation for Annual Review—Restricted Housing Unit Placement” and signed by two staff members, Michele Jerman and Alan Bennett (a “psychological services specialist” and “licensed psychological manager,” respectively). Although Mr. Johnson was identified in the report as having average intellect, the report referenced prior testing that revealed that he read at only a mid-4th grade level, and that his spelling and math achievement was at the mid-3rd grade level. (This is notable because, as someone who has been housed in isolation for literally his entire adult life, Mr. Johnson has been prevented from attending any educational classes to improve his ability to read and write.) The report identified only two “misconducts, charges, and sanctions” and listed them as having occurred in April, 1999 and August, 1997. The few clinical judgments that were contained in the report were oddly framed and difficult to interpret. Thus, the evaluators noted that, although Mr. Johnson “spoke freely,” they found that his “openness and directness was sometimes perplexing,” apparently in part because Mr. Johnson’s “perceptions bordered on suspicious, especially when he spoke about line-staff. He reported that he has a mistrust of

⁸⁹ The previously mentioned 2001 evaluation by Mr. Sacks appears to have been appended to Ms. Houck’s report.

Correctional Officers.” (Whether one agrees with such mistrust or not, it is hard to understand why mental health staff working in an isolation unit would find it “perplexing” for a long-term isolated prisoner to harbor or express it.) In any event, the evaluators noted that Mr. Johnson’s “thought process is fragmented and illogical,” even though it “makes sense to him in his own mind.” Having found Mr. Johnson “perplexing,” “suspicious,” and manifesting a “fragmented” thought process, the evaluators nonetheless concluded that there was “no acute psychopathology that would preclude his stay in the RHU.”

125. Apparently, during his January 3, 2006 evaluation, Mr. Johnson had expressed the belief that no one should be incarcerated and be forced to relinquish their liberty, and that he would “do anything” to escape from prison. However, an entry recorded in his file six months later indicated that he had disavowed that view. Thus, a “Mental Health Contact Note” dated June 2, 2006, indicated that “[h]e has since changed his mind and says he wants to be in general population so he can go to yard and exercise.” The mental health staff member (Michele Jerman) writing this report indicated that she would “ask Mr. Johnson to write a plan that will help facilitate his placement in general population” and that she would “present something” to facilitate this placement at Mr. Johnson’s next review. This was the only instance in the file that I could identify in which a mental health staff member appeared to engage with Mr. Johnson and provide him with even a modicum of meaningful guidance.

126. Setting aside the questionable tact of asking Mr. Johnson to himself “write a plan that will help facilitate his placement in general population”—that, of course, is something that staff should have had the responsibility to undertake—there does not appear to be any real follow-up

to this recommendation by the prison administration. Thus, three months later, a Mental Health Contact Note filed on September 8, 2006 (per Ms. Jerman), acknowledged simply that Mr. Johnson “reports that he would like to go to GP,” that he has been “proactive in writing a step-down program,” but there apparently had been no response to his efforts. She recommended that he be “assessed for GP, not necessarily moved, but assessed by counselor who should review all past misconduct and escape record.”

127. However, in the next Mental Health Contact Note, filed several months later, on November 30, 2006, Ms. Jerman indicated simply that Mr. Johnson had “no complaints today,” and “engaged in reciprocal conversation.” The issue of his possible transfer to general population appeared to have been dropped entirely; there was no change in his status and no mention made either of the step-down program or moving him out of isolation.

128. The Mental Health Contact Note written on January 4, 2007, indicated that Mr. Johnson was seen “in response to comments he made to his Unit Counselor recently” (which were not reported in the Note). Mr. Johnson apparently did not recognize the mental health worker and was described as “uncooperative.” The Note implied that he recently had been reviewed by the PRC, who apparently had decided not to move him to general population and, as the staff member acknowledged, “[i]t would be understandable that he might feel some discontent by this decision.”

129. A little more than a month later, on February 20, 2007, Michele Jerman, who had encouraged Mr. Johnson to devise his own step-down program and plan to facilitate his release from isolation, saw him for a routine cell-front contact. No mention was made of her earlier

suggestion that he “write a plan that will help facilitate his placement in general population” and her promise to “present something” to facilitate his transfer to general population; instead, she now merely indicated that there was “[n]o acute psychopathology present that would preclude RHU placement.” After that, as I noted above, the pattern of pro-forma, uninformative cell-front contacts unfolded, one in which “no psychological preclusions” to Mr. Johnson’s “continued housing in RHU” and “no mental health concerns” were repeated again and again, almost verbatim.

130. Ms. Jerman surfaced again in Mr. Johnson’s mental health file when she authored a “Psychological Evaluation for Annual Review—Restricted Housing Unit Placement” filed on January 12, 2007. She noted that Mr. Johnson was interviewed “because he has been in long-term, restricted housing unit placement for over two decades” (actually, 28 years). The assessment itself was superficial and, although it was more detailed than the cell-front contacts, was merely pro forma. For example, the section entitled “Analysis of Previous Evaluation Results,” Ms. Jerman simply repeated the somewhat cryptic descriptions contained in the evaluation conducted a year earlier. Her own “Current Evaluation” included her observations that Mr. Johnson “looked well and appeared energetic with no indication of acute psychopathology present,” and that he engaged in what she termed “reciprocal conversation.” However, despite apparently telling Ms. Jerman that he was “happy,” Mr. Johnson went on to say that it was an affront to human nature for people to be in prison and that he would “help himself in anyway to be a free man.” She ended by noting that “he has been requesting general population; however, he is still an escape risk.”

131. Note that the next “Psychological Evaluation for Annual Review—Restricted Housing Unit Placement” that was filed on August 11, 2008 and that purported to be a new evaluation conducted by another mental health worker, Christine Mancini, appears to be an exact replica and repeats exactly the same language as the evaluation filed the year before. In fact, the next actual “annual review” evaluation contained in the file I examined did not occur until October 4, 2010, almost four years since Ms. Jerman filed hers on January 12, 2007.

132. Unfortunately, the 2010 review, per Nancy Mayer, contained no new or meaningful psychological information either, in part because, by now, Mr. Johnson was refusing to participate in the process. Not only was the review devoid of psychological content (and focused on a detailed rehash of the escape attempt at SCI Pittsburgh in 1979, in which Mr. Johnson had participated and that resulted in his placement in isolation, now some 31 years earlier), but Ms. Mayer also repeatedly confused Mr. Johnson with someone named “Mr. Anderson.” She even did this in the final, concluding paragraph of her evaluation: “Mr. Anderson [sic] is serving a life sentence for Murder. In lieu of [sic] his poor record for escape attempts and possession of a weapon, it is unlikely he will be living in the community.”

133. Two years later, in a Psychological Evaluation for Annual RHU Psychological Report completed on January 13, 2012, Ms. Mayer (who now had clarified that Mr. Johnson was not “Mr. Anderson”) noted that “Mr. Johnson makes little to no conversation with this interviewer when attempting to speak with him in the RHU.” She nonetheless opined—apparently on the basis of nothing more than his past institutional record—that “Mr. Johnson’s presence in general population is

not a good idea since he presents a risk to both staff and inmates.” The only basis provided for this conclusion was contained in her brief but evocative summary of events at SCI Pittsburgh that had occurred some 33 years earlier. This was the last psychological “evaluation” I could find in Mr. Johnson’s prison file.

133. Again, on August 19, 2013, a Psychological Evaluation for Annual RHU Psychological Report completed on Mr. Johnson. This one was conducted by two new evaluators, Nancy Mayer and Kenneth Ley (neither of whom list advanced degrees after their names). Here, too, the “analysis” that is presented lacks any psychological information or content whatsoever. Instead, Ms. Mayer and Mr. Ley recount the story of Mr. Johnson’s attempted escape from SCI Pittsburgh in 1979, and use it as the basis for concluding “Mr. Johnson’s presence in the general population is not a good idea since he presents a risk to both staff and inmates.” That risk is based on nothing more than the evaluators’ understanding of what happened 34 years earlier. It cannot have been based on anything Mr. Johnson told them because, as they note in their report, “Mr. Johnson continues to refuse conversation when this interviewer stops by his cell in the RHU.” Despite not having spoken with him, they submitted a “Psychological Evaluation for Annual RHU Psychological Report,” and made a recommendation about his retention in isolated confinement.

134. The documentation of these various mental health contacts and “evaluations” make clear that, unfortunately, Mr. Johnson has not had the benefit of any careful, meaningful mental health monitoring or evaluation from 2003 (and perhaps long before that, if ever) until 2015 (when the last entries in the file that I reviewed appeared). Except for supposedly “annual” reviews—that sometimes did not occur for several

year intervals—Mr. Johnson has had primarily only superficial cell-front (or what inmates call "drive-by") contacts with mental health staff, most of whom, as far as I can tell, lacked advanced degrees in psychology. At least over the 10-year period they covered, even those yearly reviews appeared to be of questionable reliability and validity; they rarely if ever contained any meaningful psychological analysis or reflected any real appreciation of the significant risks of serious psychological harm to which Mr. Johnson was being subjected.

135. Indeed, the evaluators sometimes referred to Mr. Johnson by the wrong name, and sometimes repeated verbatim and at length the exact language that was used in a prior evaluation (and added little or nothing more of their own). The “mental health” conclusions and recommendations virtually always embraced a correctional rather than independent psychological perspective, justifying his continued decades-long placement in isolation in terms of his past history, one dating back some 35 or more years.

136. In addition to their failure to provide careful, meaningful psychological monitoring and any in-depth assessments of the psychological effects of three-and-a-half decades of isolation on Mr. Johnson’s mental health or functioning, there is no evidence in the records that DOC mental health staff provided Mr. Johnson with any guidance or input about how to change or modify his behavior in such a way that he might improve his chances of being released from isolation and returned to general population. The one exception occurred when, as I noted, a mental health staff member encouraged Mr. Johnson to write his own step-down program or plan but then, when he complied, soon reverted to

the use of boilerplate language to retain him in RHU, as if the step-down suggestion and his attempts to comply with it had never happened.

137. Repeatedly, instead of an independent psychological or mental health-oriented perspective, mental health staff appears to have consistently adopted a custody-oriented correctional approach to Mr. Johnson's case. They did so without at any time explicitly acknowledging the severe psychological pain and significant risk of serious psychological harm that their recommendations and those of the other DOC officials imposed on him, by continuing to retain Mr. Johnson for decades living under these extremely harsh conditions of isolated confinement.

138. As an addendum to the mental health records that I reviewed, in my interview with him, Mr. Johnson told me that he had lost all faith and confidence in the mental health staff in the DOC. He said that he had decided years not to talk about anything meaningful with them because he did not trust them, after he saw "how treacherous they are." As one example, he told me that one mental health staff person—Mr. Sacks, mentioned several times in the file, and who Mr. Johnson described to me as "a psychiatrist who wrote bad things about me"—was someone who had never actually talked to him—"he just made it up."

139. However, Mr. Johnson said that recently at SCI Frackville, and in the wake of the Department of Justice investigation and recommendations, there was a mental health staff member who seemed to take a genuine interest in him and was more responsive to his expressed concerns about being released from isolation. He says that she made it a point to speak with others in the RHU as well. [There was no documentation in the file I reviewed of this contact with this staff member, so it is likely that it occurred very recently, sometime after the last date,

July, 2015, of the records I was provided.] This staff member told him that she believed that he should be in a step down program, on his way to general population, but that correctional officials have ignored her recommendations to this effect. She apparently told him, “I tried, but they just won’t listen.”

140. It is my opinion that Mr. Johnson’s failure to receive meaningful mental health monitor and responsive care has added to the painfulness of his confinement. Mental health staff not only failed to meaningfully monitor his psychological health and attend to the adverse psychological effects of the long-term isolation to which he was being subjected but they also failed to provide him with guidance about what he could do to address what he made clear was causing him so much anguish—his retention in the RHU. It appears from the records that they mostly just ignored his pleas. With the exception of one mental health staff member who encouraged him to create and implement his own step down program (which seems to have resulted in little more than frustration on Mr. Johnson’s part when his efforts came to naught), and a mental health staff member who more recently told him that she “tried” but the prison officials “just won’t listen,” Mr. Johnson has received little solace, let alone meaningful guidance from the mental health staff over the years. In my opinion, this had added to his vulnerability, to his increasing frustration, and to his worsening sense of hopelessness and despair about his plight.

VI. THE PSYCHOLOGICAL EFFECTS OF MR. JOHNSON’S EXTRAORDINARILY PROLONGED ISOLATED CONFINEMENT

141. As I noted above, despite being held in very severe isolation units for approximately 37 years, Arthur Johnson appears to have been given little or no careful mental health attention, evaluation, or treatment (at least over the approximately 10 year period for which documentation was available for me to review). In his personal interview with me, Mr. Johnson confirmed that this has been the case throughout his entire, lengthy period of confinement in various Pennsylvania DOC's isolation units.

142. Mr. Johnson told me that there were times when he was singled out and treated especially badly—including what he remembers at three separate occasions when he was placed naked, “in the box” in the 1980s, inside the special glass cells at SCI Huntingdon (that eventually were closed), and another time when he was kept in a cell that had been built especially for him, in which correctional officers did constant monitoring and a bright light was kept on inside the cell around-the-clock. Otherwise, with the exception of about a year spent at the federal penitentiary in Lewisburg, Pennsylvania, he had been in one or another of these isolation units.

143. During this 37 year period, Mr. Johnson has spent all of his time locked in his cell, except for the five hours a week (one hour, five times a week) he is allowed to go to recreation pens, and the approximately 30 minutes he is allowed to shower (10 minute showers, three times a week). In each instance, when he is taken out of his cell, he is first placed in handcuffs, and tethered to a chain or leash, so that correctional officers can escort him (to yard or the showers). The Annex unit that he is in now is not much different from the other isolation units he has been housed in, except it has a hard plastic shield or covering on

the outside of the cell door. As Mr. Johnson described it, “it makes it more closed in and you can’t really talk to people. If you try, you have to yell. Also, [you] can’t see in or out.” The front of the cell has one long slot for the correctional staff to see in. Otherwise, there is no visibility in or out. He said that there are still mentally ill prisoners in his unit on a long-term basis, despite the Department of Justice recommendations against this practice. He said, “I have, now, guys in my unit who are screaming, banging on the door, hearing voices.” Apparently, the only prisoners who are removed from the unit are those who are overtly suicidal.

144. On rare occasions—he estimated no more than once every couple years—he has received a social visit from a family member or loved one. Because he has been housed in an isolation unit for the last 37 years, these visits have all been conducted on a non-contact basis. As he told me, “the last time I shook someone’s hand or hugged somebody was 1979.” Mr. Johnson also told me that no one in his immediate family is still alive. As I noted, he never knew his mother, who died when he was very young. His grandmother (who raised him), his father, and his two brothers are now all deceased, having died while he was in isolation.

145. In one of the saddest moments in my interview with him, Mr. Johnson told me that no prison officials had come to him to notify him on the occasions of his family members’ deaths, and that he received no special bereavement phone calls to home in the wake of their passing. Instead, he learned unceremoniously through letters he received from other family members, telling him that these key people in his life had passed away. He was left to mourn these profound losses by himself, alone in his cell. As a result of these deaths, he said, there are now only a few family members left who know, and very few people who can come visit

him. Clearly, during the time he has been held in isolation he has lost his most intimate and important relationships and, in fact, nearly all of his connections to the outside world.

146. Mr. Johnson's exceptional resilience has enabled him to somehow endure this extraordinarily long period of isolation. But the ordeal has finally worn him down psychologically. He told me that he has undergone many changes over the years, losing his bitterness and also his "fight." Beyond that, however, he has also begun to lose his will to go on. He said simply, "I can't stand to live like this." He said he sits in his cell, and cannot shake the feeling that "this is no way to live" and that his life is "terrible, terrible, terrible." He also now fears losing his mind: "I don't want to be crazy. I want to hold onto my self respect. [I] just keep trying, but it is a struggle, all the time. [I am] fighting depression.

147. Mr. Johnson told me that he was raised not to complain about things, and that he has tried not to complain about his treatment. Even now, when he feels as though he is going crazy, he fights against it—"strong men don't complain, they just endure." And, yet, when I asked him about whether there were any specific symptoms that were bothering him, now, while in isolation, he was able recognize and acknowledge a great many of them. The wide range of maladies and signs of dysfunction he reported are associated with psychological trauma and stress and a number of psychopathological reactions that often occur in isolated confinement.

148. The pattern was one very similar to ones I have recorded among many prisoners who have served very long terms in solitary confinement (although, as I said, few prisoners in my experience have ever served as long in isolation as Mr. Johnson). It is my opinion that the

extraordinary length of isolated confinement, combined with Mr. Johnson's now-advanced age, have rendered him especially susceptible to both the emotional pains and psychological risks of this extremely harsh and severe form of imprisonment.

149. Mr. Johnson reported that he suffers from sleeplessness that has gotten progressively worse over the years. Even when his unit is relatively quiet at night, he said, he still lies awake in bed, unable to sleep. Recently he said he has been feeling that he is on the verge of an emotional breakdown, and he has struggled to ward off those feelings. He said that when he was young his grandmother would tell him during hard times that "tomorrow will be a better day," so he tries to go to sleep to bring that day around sooner, but this technique no longer works and he is worried about where these feelings will lead. He also reported that he is regularly bothered by ruminations—he is not able to control what he thinks about or make bad thoughts go away. They get stuck in his mind, and remain, no matter what he does to try to distract himself. On the other hand, he has experienced increasing difficulty concentrating or focusing his attention on the things he wants to focus on or accomplish. He is very worried that his attention wanders constantly, no matter how hard he tries, he cannot stay focused long enough to write long letters, or read for any significant period of time, and he is very forgetful. All of these are new developments they concern him very much. In fact, he is extremely worried about what he perceives as his overall physical and mental deterioration in isolation—that it has taken an irreversible toll on him.

150. In addition, Mr. Johnson reported that he recently has become increasingly irritable over small or minor things that in the past would not have bothered him. Notably, he reported that he now struggles

greatly with depression. He said, “I try to go to sleep to make it go away, or do something” to distract himself from the feelings of hopelessness, but “it doesn’t work well anymore.” He assured me that he is not actively suicidal but then he qualified that statement by saying “I don’t care about living or dying anymore. I know prison is bad, but sometimes you feel like you can’t take living like this.”

VII. CONCLUSION: Arthur Johnson’s Long-Term Solitary Confinement Cruelly Inflicts Extreme Psychological Pain and Lasting Damage That Derives In Large Part From the Experience of Social Death To Which It Has Subjected Him

152. The principles that are now used to limit the use of solitary confinement—that exposure should be brief, employed only when absolutely necessary and as a last resort, and that vulnerable populations should be entirely excluded from such confinement—are being flagrantly violated in this case. Arthur Johnson has been kept in solitary confinement for an extraordinary amount of time—an amount that greatly exceed any of the limits recommended or countenanced by any legal, mental health, or human rights organization of which I am aware.

153. The events that are presumably being used to justify his continued isolation occurred in 1979. The record of his confinement over the last 13 years that I reviewed contained no evidence of dangerous or disruptive behavior that could possibly justify continued isolation. Thus, there is no convincing showing of any remotely plausible necessity or need at the present time.

154. Mr. Johnson’s advanced age and psychological frailty now render him especially vulnerable to the pains and harms of continued

isolated confinement. Despite his numerous “contacts” with mental health staff (overwhelmingly cell-front), he has received no more than superficial psychological monitoring and care. From the records I reviewed, he does not appear to have been given a clear explanation for why he continues to be kept for decades in isolation (despite years of conforming behavior), and has not been provided with any opportunity or pathway to change his circumstances (i.e., he has not been told what he can do to make his suffering end). The fact that he continues to be subjected to severe psychological pain without a clear rationale or the means with which to reduce or end it creates a feeling of helplessness that exacerbates the pain of his confinement.

155. Arthur Johnson is now approaching his mid-60s and has spent more than half of his life—virtually all of his adult life—living in isolation, alone in his cell. Notwithstanding his significant resiliency and past ability to withstand his harsh and deprived conditions of confinement without completely breaking down or decompensating psychologically, his age-related psychological vulnerability has placed him in an especially precarious and dangerous state. As I noted earlier, Mr. Johnson is suffering from what can be termed “social death”—having few if any meaningful social contacts from which to derive nurturing support for so many years, and becoming acutely aware of the deep and irreplaceable losses he suffered throughout this long ordeal. His dwindling connections to family, friends, and others—all of his immediate family members died during the decades that Mr. Johnson was in isolation—and his increasing inability to function as a social being have left him deeply sad and profoundly alone.

156. The many years of painful and harmful isolated confinement have taken a toll and, combined with the psychological fragility that comes from his advanced age, have exacerbated his pain and increased his risk of harm. Mr. Johnson reported to me that he can feel himself faltering and that his mental state has noticeably deteriorated. He feels he has reached and clearly exceeded the limits of his considerable tolerance and resiliency.

157. Whatever justification the Pennsylvania DOC may have had for placing Mr. Johnson in isolation in the distant past, his long-standing nonviolent prison record and his increasing age provide ample evidence that those justifications no longer exist. In my opinion, Mr. Johnson should be moved from his isolated confinement immediately, to reduce his unjustified suffering and prevent further and perhaps irreversible additional damage from occurring.

158. Finally, as a matter of sound correctional practice and as an essential psychological safeguard, although Mr. Johnson's release from isolated confinement should occur immediately, it should be accomplished through a meaningful and thoughtfully structured "step down" program in which he moves, in stages, to an increasingly social environment. Mr. Johnson has been deprived of normal social contact and social interaction for three-and-a-half decades. He will need to accommodate to this transition over time, to become gradually familiar with, and be eased back into, the norms of social life.

Craig Haney Ph.D., J.D.

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