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Written Testimony of Professor Laura Rovner
Before the United States Senate Judiciary Committee,
Subcommittee on the Constitution, Civil Rights, and Human Rights
Hearing on Reassessing Solitary Confinement II:
The Human Rights, Fiscal, and Public Safety Consequences

February 24, 2014

Chairman Durbin, Ranking Member Cruz, and Honorable Subcommittee members,

Thank you for the opportunity to submit testimony to the Subcommittee for its second hearing on Reassessing Solitary Confinement. I am an Associate Professor of Law and Director of Clinical Programs at the University of Denver Sturm College of Law, where I also founded and teach in the Civil Rights Clinic. The lawyers and students in the Civil Rights Clinic have represented a number of prisoners held in solitary confinement in cases asserting that the conditions in Colorado's state and federal supermax prisons violate the Eighth Amendment's prohibition against cruel and unusual punishment and the Due Process Clause, as well as the federal disability discrimination statutes.[1]

I want to begin by thanking the Committee for holding this second hearing. In the nearly two years that have elapsed since the Committee's first hearing, evidence has continued to mount about the devastating effects of solitary confinement. The last year alone has seen position statements from the American Psychiatric Association, the American Public Health Association, and the Society of Correctional Physicians (among others) condemning the use of solitary confinement, especially for people with mental illness.[2] And two weeks ago, researchers released the results of a study documenting that prisoners who are held in solitary confinement are seven

[1] *Silverstein v. Bureau of Prisons, et al*., 07-cv-02471-PAB-KMT (D. Colo.) (lawsuit claiming that BOP's confinement of prisoner in extreme isolation for 28 years constitutes cruel and unusual punishment); *Saleh, et al. v. Bureau of Prisons*, 05-cv-02467-PAB-KLM (D. Colo.); *Rezaq v. Nalley*, 07-cv-02483-LTB-KLM (D. Colo.) (consolidated on appeal *Rezaq v. Nalley*, 677 F.3d 1001 (10th Cir. 2012)); *Anderson v. Colorado Dep't of Corrections* 887 F.Supp.2d 1133 (D. Colo. 2012); *Sardakowski v. Clements*, 12-cv-01326-RBJ-KLM (D. Colo); *Decoteau v. Raemisch*, 13-cv-03399-WJM-KMT (D. Colo); *Oakley v. Raemisch*, 10-cv-03052-CMA-MJW (D. Colo).

[2] Position Statement on Segregation of Prisoners with Mental Illness, American Psychiatric Ass'n, Dec. 2012 (mandating that mentally ill prisoners should never be subjected to long-term solitary or isolated confinement of more than 3-4 weeks except under the most extreme circumstances); AMERICAN PUBLIC HEALTH ASS'N, SOLITARY CONFINEMENT AS A PUBLIC HEALTH ISSUE, POLICY NO. 201310 (2013), (detailing the public-health harms of solitary confinement; urging 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 asserting that "[p]unitive segregation should be eliminated"); SOCIETY OF CORRECTIONAL PHYSICIANS, POSITION STATEMENT, RESTRICTED HOUSING OF MENTALLY ILL INMATES (2013) ("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).

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times more likely to engage in self-harm.[3] In short, the more we learn about long-term isolation, the worse the picture becomes.

The testimony I submitted for this Committee's first hearing in 2012 was devoted to the conditions of confinement at the ADX, the federal supermax prison in Florence, Colorado.[4] For this hearing, I seek to share some of the information about the use of solitary confinement by the Colorado Department of Corrections (CDOC). In the course of litigating several cases, our Legal Clinic has gathered a substantial body of evidence about CDOC's troubling use of long-term isolation for prisoners who are seriously mentally ill. As the testimony submitted about other states' correctional systems and the Bureau of Prisons makes clear, Colorado is not unique in this practice. But because Colorado has made significant representations about sweeping reforms in its use of isolation, especially for prisoners with mental illness, I want to urge some caution and a closer examination of exactly what is transpiring on the ground.

To do so, I draw on the experience of one of those prisoners – James Sardakowski—both because his situation is profoundly troubling and because we have learned through our experiences litigating against the CDOC that his situation is not unique. I also do so because the nature and location of this hearing makes it virtually impossible for the Subcommittee to hear from people who are currently in long-term isolation, especially those like Mr. Sardakowski who are seriously mentally ill. For that reason, I have tried throughout this testimony to quote verbatim from Mr. Sardakowski himself, so that the Subcommittee can hear about his experience, to the extent possible, in his own voice.

James Sardakowski's Experience As a Mentally Ill Prisoner in Solitary Confinement in the Colorado Department of Corrections

Mr. Sardakowski is seriously mentally ill and developmentally disabled, and he has been held in solitary confinement by CDOC for over four years. While the record is unclear about why Mr. Sardakowski initially was placed in administrative segregation in the Colorado State Penitentiary (CSP), many of the behaviors cited by prison officials relate to his mental illness. None of them constitutes an act of violence.

In a declaration provided in his case, Mr. Sardakowski describes his experience in CSP:

> *The cells in CSP were no bigger than 4 steps of mine . . . It's always back and forth. The solid furniture consisted of either cement or steel. There was basic furniture one needs to have to live in it, i.e. a toilet, a bed, a desk, and a few storage areas. All cell walls are white, and the cell doors change color by what unit you're in.*

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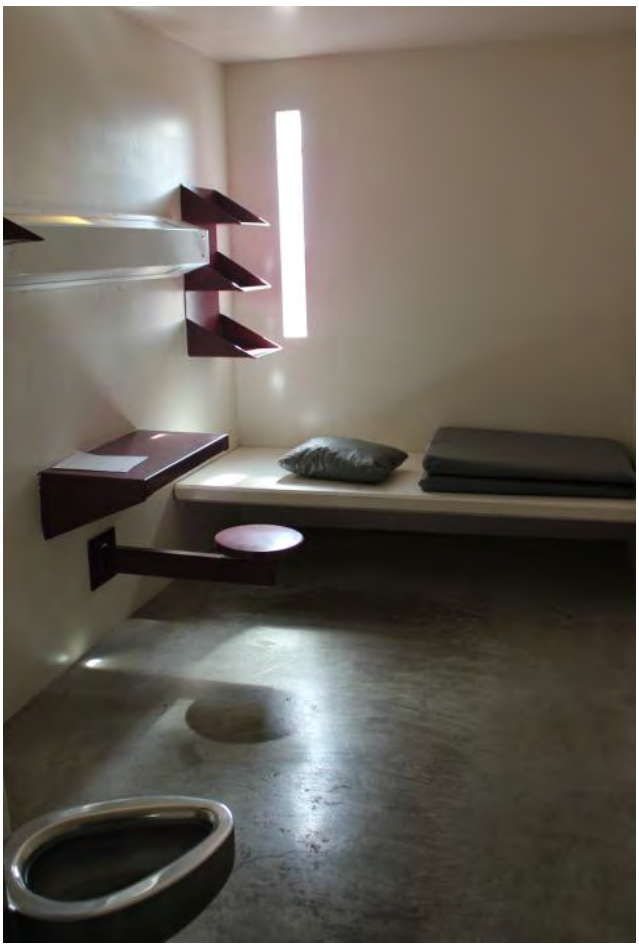
[3] *See* Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104:3 AM. J. PUBLIC HEALTH 442, 442-447 (March 2014).

[4] One of the prisoners discussed in that testimony was Thomas Silverstein, a federal prisoner who at that time had been held in extreme isolation by the Bureau of Prisons for 28 years. Our clinic represents Mr. Silverstein in his lawsuit challenging the constitutionality of his prolonged isolation, which was dismissed by a federal district judge in 2011. *See Silverstein v. Bureau of Prisons, et al.*, 2011 WL 4552540 (D. Colo. 2011, Brimmer, J.). Nearly two years later, Mr. Silverstein remains at ADX and his conditions of confinement are unchanged. His case is currently on appeal to the U.S. Court of Appeals for the Tenth Circuit.

I'm allowed only two books and two magazines, which they need to swap out every time a new book or magazine has come in. One of my two personal books was a dictionary, and the other one was a Bible. I read my dictionary so much that I wore it out. They confiscated it because it was so worn out and taped. I sent a letter to Miriam Webster to ask for a donation so I can have a dictionary. It's like losing a best friend.

My days are consisted on getting up between 4:30 am and 5:30 am, and find something on TV, if I have one. If no TV, then I'll pick up a book or if I got legal stuff then I read that. I get breakfast around 6:30 am to 7:00 am, dependent on the day and unit you're in. Then I return the trays after about 30 to 45 minutes after delivery. Between the time I'm done eating and lunch I go watch more TV, or read and study the law or read a book if no TV. After lunch trays are returned I go back to sleep. This will be around 11:30 am to noon. I sleep until 2:30 to 3:30, then I repeat the breakfast and lunch time routine until medline and dinner are done. Then I go to sleep around 7:30 pm. Then the next day starts and continues as the same.[5]

This photo depicts a cell in CSP:



[5] *Sardakowski v. Clements*, 12-cv-1326-RBJ-KLM (D.Colo), Doc. 118, Decl. of James Sardakowski at 15-16.

Unsurprisingly, since being placed in isolation, Mr. Sardakowski's already-fragile mental condition has deteriorated. He has repeatedly engaged in self-harm, including attempted castration, banging his head against the wall, and biting his lips and hands until he bleeds.

CDOC's response to Mr. Sardakowski's self-harm has been to subject him to punitive (and even more isolating) conditions on "mental health watch," where he is placed in a small, windowless cell that is stark and completely barren. The "bunk" is a long, thin concrete slab with no mattress, and the bright lights inside the cell are kept on all the time. Mr. Sardakowski describes it as "*very cold in the suicide cells. So it's like punishment. It makes me feel subhuman.*"[6]

This is a photograph of the mental health watch cell:

[6] *Sardakowski v. Clements*, Decl. of James Sardakowski, attached as Exh. 1.

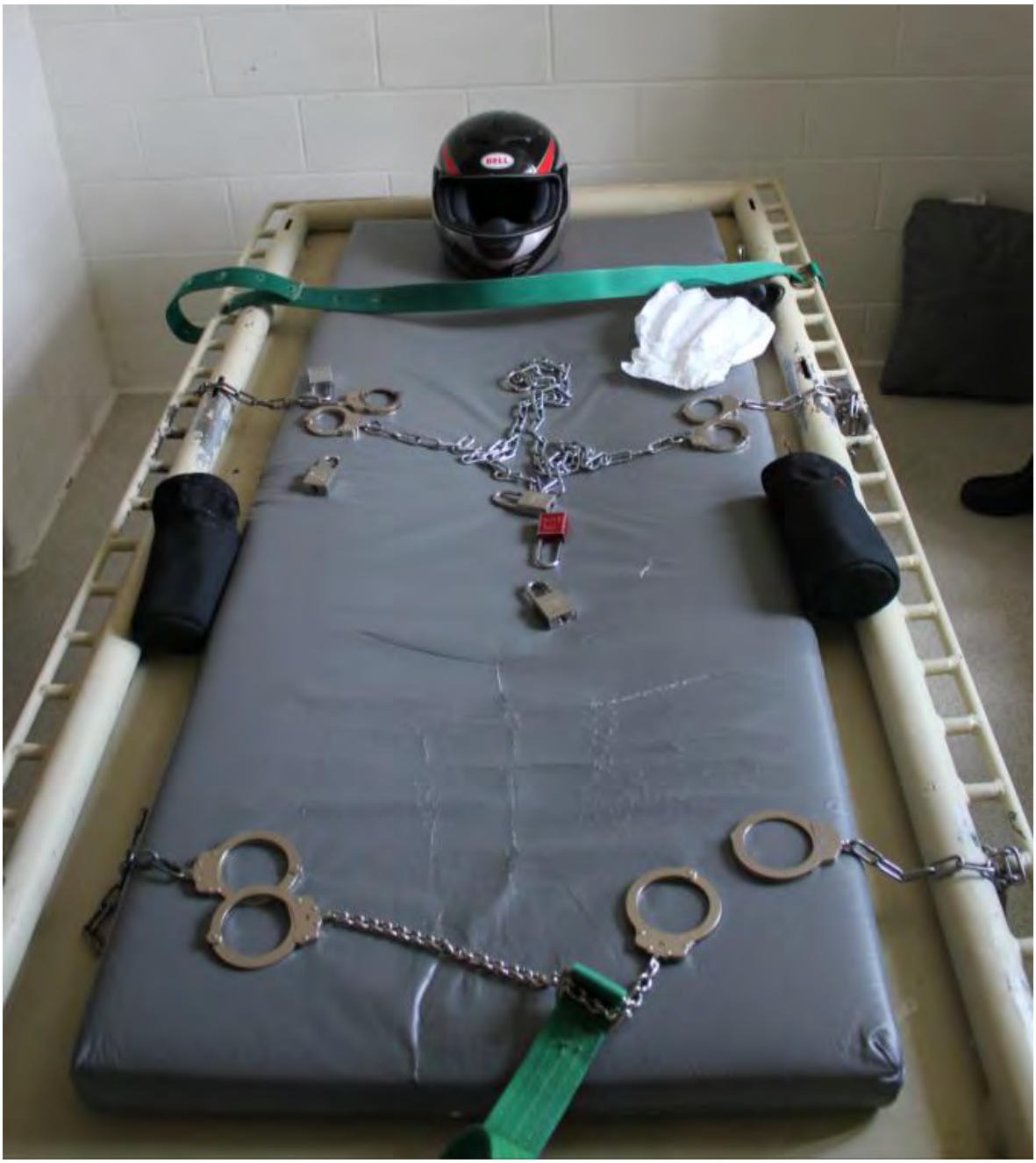
When Mr. Sardakowski is placed on mental health watch, he is given only a suicide smock and blanket but is otherwise naked. Sometimes he is placed in "ambulatory restraints" – a belly chain, leg irons, a motorcycle helmet covered in electrical tape, and "mitts" – tube-like devices placed on his hands that prevent him from grasping anything. He estimates that he has been put on mental health watch "*more than fifteen times I would say, less than forty though – or I hope that it is – while in CDOC.*"[7] Sometimes he has remained in these restraints in the mental health watch cell for days.

This is a photograph of the ambulatory restraints to which Mr. Sardakowski has been subjected:

On several occasions when Mr. Sardakowski has been taken to the infirmary for purported treatment after engaging in self-harm, CDOC staff have chained him to a bed with immobilizing

[7] *Id.* at 17.

four-point restraints, wearing a diaper, for days at a time. According to CDOC staff, there is no set maximum amount of time that a prisoner can be kept restrained this way. Describing his experience of being four-pointed, Mr. Sardakowski states, *"it makes me feel subhuman, like I'm some type of wild animal that needs to be controlled and tamed. . . . You are so tied down that every two hours staff must come in and pump your limbs*."[8]



If and when Mr. Sardakowski is able to "contract for safety" – that is, when he can promise CDOC staff that he will not hurt himself any further – he is returned to his solitary cell.

[8] *Id.* at 19-20.

CDOC's Mental Health Treatment Program

In 2010, CDOC created the Offenders with Mental Illness (OMI) program at CSP, which was supposed to provide prisoners with serious mental illness both intensive mental health treatment as well as a way to progress out of solitary confinement. Mr. Sardakowski received neither. He was not the only one; by CDOC's own admission, the OMI program had a 61% failure rate.[9]

Recognizing the significant limitations of the OMI program (including CDOC staff's own admission that it is "hard to run mental health and ad seg programs at the same time in the same facility"), CDOC created a new program in February 2013 – the Residential Treatment Program (RTP). The new RTP removed mentally ill prisoners from administrative segregation at CSP and placed them in a prison across the street where they could presumably receive treatment for their psychiatric conditions. The RTP is described by CDOC as "a program [in] which offenders with mental illness receive individual and group therapy, educational programs and recreational activities in controlled conditions of confinement." Like the OMI program, the RTP uses "planned incentive level systems to promote pro-social behavior and meeting targeted behavioral goals."

One year ago, Mr. Sardakowski was placed in the RTP. Although the program is designed to take six months or less to complete, prisoners with serious mental illness like Mr. Sardakowski often cannot progress in linear fashion through the levels of the program precisely because of their mental disabilities. As Mr. Sardakowski explains:

> *It's hard for me to progress because the times are too far apart from level to level. I can comprehend two weeks, but beyond that it gets really stressful. I get too stressed out, trying to get the next level and stay out of trouble. The byproduct is my behavior, because of my stress. You say something wrong, you get your level taken. It's hard for me to control what I say. I'm stuck in this rut. I'm stressed about the timeframe and all the requirements. All these little stress factors build up to a volcano and I explode. I don't have nobody to talk to relieve my stress. The level system is too long for me to progress.*
>
> *The staff says you go back to GP [general population] if you pass your Level 8. This is like saying to me: "you will get released tomorrow and become the president tomorrow evening." It's not possible for me to get this notion.*[10]

For Mr. Sardakowski and other men with serious mental illness, the isolating conditions in the RTP perpetuate a vicious cycle that is seemingly impossible to break because those conditions contribute to the very behavior that perpetuates CDOC's decision to keep them in segregation:

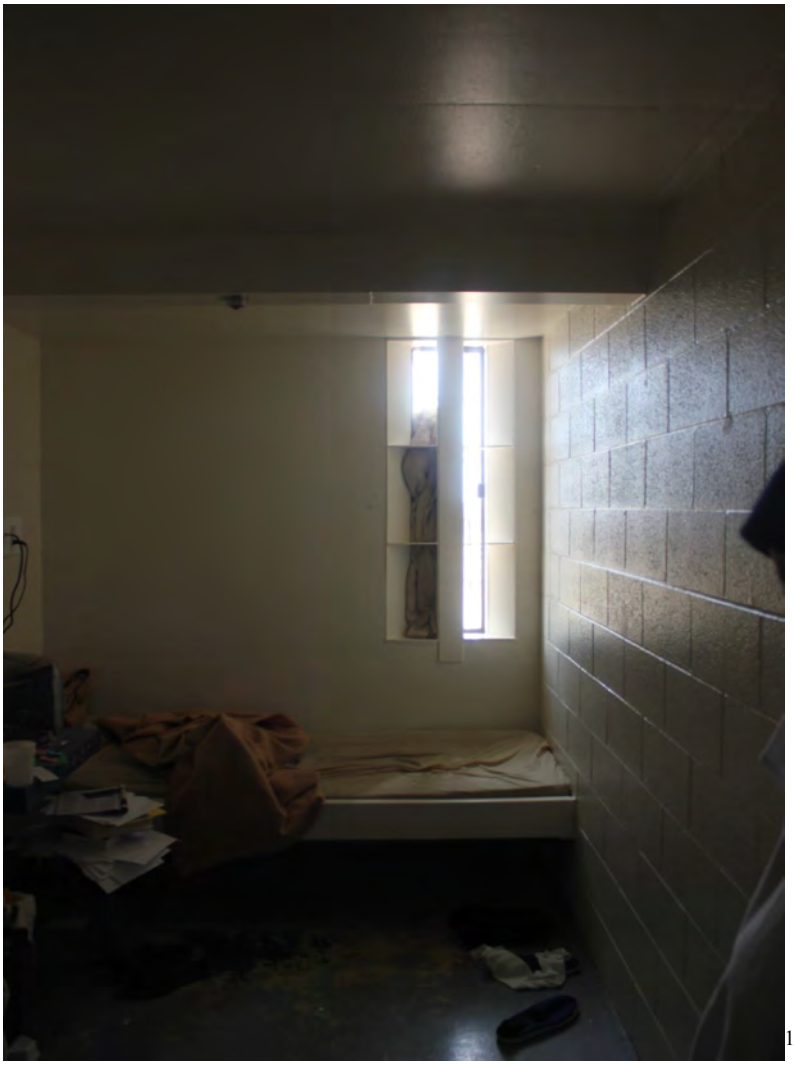
> *I don't feel like I have control over my behavior. My behavior is randomly picked. If I feel upset then I act out behaviorally, i.e. tying off*[11] *[my testicles], etc. It's worse in ad seg, because I can't walk away from the situation to try to think rationally. You build up a lot of stress that you can't release. I implode, e.g. harm myself or explode, e.g. get*

[9] Offenders with Mental Illness Report, submitted to House & Senate Jud. Committees Jan. 31, 2013, p. 5.
[10] Sardakowski Decl. at 30.
[11] This is the phrase that Mr. Sardakowski uses to describe his attempts at self-castration.

> *sprayed with pepper spray, which affects the rest of the facility (they have to go on lockdown to deal with me). I never reached this level of self-harming tactics until I got to ad seg. In GP I could get to the point where I could think about my actions, but here, what do I have? I can stand at the door, then walk back to my bunk.*[12]

If anything, the physical conditions of confinement in the RTP are as austere and oppressive as those in CSP's administrative segregation units, especially at the lower levels of the program where Mr. Sardakowski and other mentally ill men are consigned to stay when they are unable to comply with program requirements due to their mental illnesses.

Indeed, in the lower levels of the RTP, almost every condition of Mr. Sardakowski's confinement is the same as when he was in administrative segregation at CSP: he spends up to 23 hours per day locked in his single cell, which is roughly the same dimensions as his cell in CSP. This is a photo of his cell in the RTP:

 [13]

[12] Sardakowski Decl. at 31.
[13] Sardakowski Decl. at 24.

As was the case when he was confined in administrative segregation at CSP, in RTP, Mr. Sardakowski eats his meals alone in his cell, next to where he uses the toilet. He is restrained and escorted anywhere he goes, including recreation, medical and legal visits. He explains that "*this makes me feel like a dangerous animal that has no control, and that will attack anything that dares to glance at me. Which I'm not. I'm not sub-human at all*."[14]

CDOC Fails to Address Issues of People with Mental Illness in Solitary Confinement By Changing Definitions Rather Than Practices

Rather than address Mr. Sardakowski's situation, the Colorado Department of Corrections has chosen to fight the lawsuit he filed tooth and nail, twice filing motions to dismiss the case, which is currently scheduled to go to trial on March 17, 2014. One of the bases they cite for doing so is CDOC's claim that Mr. Sardakowski does not have a "major mental illness" (though the Department concedes that he is "seriously mentally ill").

The terminology is important because it is the terminology that allows for CDOC to assert that "we have gotten the number of severely mentally ill inmates in Ad Seg down to the single digits."[15] In fact, what has happened is that CDOC has created a new category of mentally ill people—those with what it calls "major mental illness." A person such as Mr. Sardakowski can still be seriously mentally ill—and many are—but if he has not been diagnosed by CDOC as having one of the particular mental health conditions that qualify as a "major mental illness," he isn't included among those considered mentally ill for purposes of CDOC's figures.

CDOC also employs a limited definition of "administrative segregation" that results in underreporting of the numbers of prisoners in solitary confinement. CDOC asserts that if a person is housed in the RTP, he is, by definition, not on "administrative segregation status." Although RTP is not called "administrative segregation," prisoners such as Mr. Sardakowski are held in classic solitary confinement conditions in the lower levels of that program. By asserting that the RTP is not administrative segregation, CDOC can represent that mentally ill prisoners in RTP (or elsewhere in CDOC) are not in solitary confinement. But doing so fails to account for all of those who are housed in the lower levels of the RTP, or are held elsewhere in CDOC in conditions like those I have described above.

I share this observation because changing definitions rather than practices helps no one – not this Subcommittee, which is endeavoring to understand the nature and scope of the issues related to long-term isolation; not the Colorado Department of Corrections, which has made a stated commitment to dramatically reducing (if not eliminating) the use of penal isolation for mentally ill prisoners; and certainly not Mr. Sardakowski and the seriously mentally ill men like him who continue to deteriorate in solitary confinement.

The Extreme Nature of the Solitary Confinement Conditions in America's Prisons Impacts Our International Credibility on Human Rights Issues

Harold Koh, legal advisor to the State Department, has described the United States as the world's indispensible force for human rights. Yet solitary confinement conditions like those in our state

[14] *Id*. at 24-25.
[15] Rick Raemisch, *My Night In Solitary*, N.Y. TIMES, Feb. 20, 2014.

and federal supermax facilities are inconsistent with international human rights standards[16] and have been roundly condemned, including by the United Nations Special Rapporteur on Torture at the 19th session of the U.N Human Rights Council. At that session, the Special Rapporteur called on all countries to ban the use of solitary confinement, except in very exceptional circumstances, as a last resort, and for as short a time as possible. The Special Rapporteur concluded that solitary confinement is a harsh measure that may cause serious psychological and physiological adverse effects. He found that solitary confinement can amount to cruel, inhuman or degrading treatment or punishment and even torture. He recommended both the prohibition of solitary confinement and the implementation of alternative disciplinary sanctions. He also called for increased safeguards from abusive and prolonged solitary confinement, and the universal prohibition of solitary confinement exceeding 15 days.[17]

While the U.S. is dismissive of international criticism of its own prison conditions, in judging other countries' human rights records, the U.S. State Department has regularly treated the use of prolonged solitary confinement as a human rights violation.[18] If the U.S. is to continue to hold itself out to the world as a standard-bearer of human rights, we must look closely at the use of solitary confinement here at home.

Conclusion

It is clear that our state and federal correctional systems need to reduce the use of solitary confinement, especially for prisoners with mental illness. But it is equally clear that the path

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[16] The U.S. has ratified the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture, both of which prohibit torture or other cruel, inhuman or degrading treatment or punishment. Article 10 of the ICCPR further requires that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." The UN Human Rights Committee, the ICCPR treaty monitoring body, has further emphasized that the absolute prohibition of torture or cruel, inhuman or degrading treatment under international law "… relates not only to acts that cause physical pain but also to acts that cause mental suffering …" and that prolonged solitary confinement may amount to torture or other ill-treatment.

[17] Interim Rpt. of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, delivered to the General Assembly, U.N. Doc. A/66/268 (Aug. 5, 2011).

[18] Glenn Greenwald provides a powerful summary of this tendency:

> [T]he U.S. Government routinely condemns similar acts—the use of prolonged solitary confinement in its most extreme forms and lengthy pretrial detention—when used by other countries. See, for instance, the 2009 State Department Human Rights Report on Indonesia ("Officials held unruly detainees in solitary confinement for up to six days on a rice-and-water diet"); Iran ("Common methods of torture and abuse in prisons included prolonged solitary confinement with extreme sensory deprivation . . . Prison conditions were poor. Many prisoners were held in solitary confinement . . . Authorities routinely held political prisoners in solitary confinement for extended periods . . ."); . . . Israel ("Israeli human rights organizations reported that Israeli interrogators . . . kept prisoners in harsh conditions, including solitary confinement for long periods"); Iraq ("Individuals claimed to have been subjected to psychological and physical abuse, including . . . solitary confinement in Ashraf to discourage defections"); Yemen ("Sleep deprivation and solitary confinement were other forms of abuse reported in PSO prisons . . .").

U.N to Investigate Treatment of Bradley Manning, SALON (Dec. 23, 2010).

forward requires us to do so in ways that acknowledge the harm caused by prolonged isolation, regardless of the label we use to describe it.

Thank you again for holding this hearing. While I urge the Subcommittee to pursue an approach that dramatically reduces the use of solitary confinement in our nation's prisons, "[I] do so in a spirit that recognizes the enormous burden on those responsible for actual policy decisions. But in the end, in a democracy, that is all of us, and so we must all take responsibility for what we now do and become as a nation."[19]

[19] CHARLES FRIED & GREGORY FRIED, BECAUSE IT IS WRONG: TORTURE, PRIVACY AND PRESIDENTIAL POWER IN THE AGE OF TERROR 17 (2010).