



**SOLITARY:
THE FAMILY
EXPERIENCE**

**CITIZENS FOR
PRISON REFORM**



**OPEN MI
DOOR**



ACKNOWLEDGEMENTS

This report is dedicated to the thousands of people who have suffered solitary confinement and their families who endured it with them.

RESEARCH METHODS

Information in this report was primarily compiled from interviews and surveys of 30 family members who have or have had a loved one incarcerated in solitary confinement in a Michigan prison, which is defined as isolated confinement for more than 20 hours a day. The percentages attributed to family respondents are based on a small sample size relative to over 35,000 people currently in Michigan prisons. Respondents did not comment on isolation in jails or juvenile facilities so those separate institutions were not addressed in this report. CPR recognizes that the voices of other key stakeholders, including solitary survivors, correctional officers, and healthcare staff are a vital part of this discussion and, although not specifically explored in this report, must be consulted as part of systemic reform. Citizens for Prison Reform is grateful to the numerous families who were willing to share their stories and use their lived experiences to recommend changes.

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Citizens for Prison Reform (CPR) is a family-led organization that engages, educates, and empowers those affected by crime and punishment to advance their constitutional, civil and human rights. The Open MI Door Campaign is dedicated to ending the use of solitary confinement and creating safe alternatives to segregation. For more information about the Open MI Door Campaign to end solitary confinement, visit www.micpr.org/Open-MI-Door.

EXECUTIVE SUMMARY:

THE IMPACT OF SOLITARY CONFINEMENT ON FAMILIES

Despite its name, “solitary confinement” impacts more than just the person in prison. Family members suffer greatly when a loved one is sent to isolated confinement for more than 20 hours a day. Despite the well-known dangers associated with “the hole” - extreme loneliness, psychiatric distress, increased self-harm, and high rates of suicide - families are often cut off from visits and communications with loved ones during this time.

Families worry greatly about the health and well-being of their loved ones inside, unsure if they are receiving adequate access to medical or mental healthcare or being treated fairly. Families know that their loved ones are at the mercy of the correctional officers who guard the unit; yet, when they make contact with officers, they are often met with disregard and disdain. The stress that solitary has on family members is alarming and largely undocumented.

This report highlights the mental, emotional, social and even physical toll that solitary has on families of incarcerated loved ones in the Michigan Department of Corrections (MDOC) and provides recommendations based on their experiences to develop safer, more humane alternatives to solitary confinement.

THE REALITIES OF SOLITARY CONFINEMENT

Picture your dearest loved one in your mind - your child, spouse, parent or grandparent. Now imagine them being locked in a concrete room the size of a parking space, enclosed with a solid steel door, for 23 to 24 hours a day. They have no outside contact with other human beings, except for a voice through the food slot, where they are given three meals a day - often only half portions or sometimes none at all. The noise is either unbearably loud from others shouting or unbearably silent, a torturous form of sensory deprivation. In the summer, the temperature could feel over 100 degrees, with no air circulation.

If they react or cry out for help, they may be hog-tied, gassed, tased, have their water turned off, or deprived of sleep. Five days a week, they are permitted out of their cell for one hour, in a caged yard, if they're lucky, and three 10-minute showers a week.

They have almost no access to employment, education, or rehabilitative programs and limited reading materials or personal property. They may only have non-contact visits from family, separated by plexi-glass while they are bound in shackles. You might have a weekly 15-minute phone call but, more often than not, you are left to wonder and worry for their safety and well-being. This could go on for days, weeks, months, or even years.

Sadly, this is the reality for over 3,000 families, whose loved ones are forced to endure some form of solitary confinement in the Michigan Department of Corrections (MDOC) each year.

A silhouette of a person's head and shoulders is centered in the foreground, looking out a window. The window has vertical bars, suggesting a prison cell. The light from the window creates a strong backlighting effect on the person's silhouette. The text is overlaid on the lower part of the image.

**"He was the one enduring the torture
but it felt torturous to me, too."**

Despite the perception that these prisoners are the “worst of the worst,” most people in solitary confinement are there because of mental illness or because they are “nuisance” prisoners, who repeatedly have low-level violations.¹ The vast majority of these individuals are people of color; sixty-five percent of those in segregation are Black.²

In 2015, the federal class action *Ashker v. Governor of California* made a clear and compelling case that the use of prolonged solitary confinement was tantamount to cruel and unusual punishment and denied people in prison their right to due process.³ Although U.S. and international law is clear that all forms of torture and other cruel, inhumane and degrading treatment are prohibited, this dangerous practice continues to be used in Michigan with few restrictions.

MDOC SEGREGATION POLICIES

ADMINISTRATIVE SEGREGATION: 835 PEOPLE⁴

Administrative segregation is the most restrictive level of security classification and the most common type of solitary confinement.⁵ A prisoner may be transferred to administrative segregation as a result of a Class 1 misconduct violation or reclassified to administrative segregation if an MDOC official determines that their behavior warrants isolation. There is no limit on the number of days, weeks, months or years someone may be placed in “ad seg.” Historically, the norm was to keep “trouble makers” in administrative segregation for years and years. Today, it is more common for individuals to cycle in and out after a number of months, returning to level IV or V (which is still very restrictive) and then ending up back in segregation.

TEMPORARY SEGREGATION: 319 PEOPLE⁶

Temporary segregation is used to remove prisoners from the general population during intake, pending a hearing for a Class I misconduct violation, investigations or interrogations, or transferring to a different facility. Placement in temporary segregation is limited to 7 days in most circumstances.

PUNITIVE SEGREGATION: 130 PEOPLE⁷

Punitive segregation, also known as detention, is used as punishment for Class 1 misconduct violations, such as assault, sexual misconduct, substance abuse, or other dangerous or threatening behavior. Punitive segregation can last anywhere from 30 days to one year.

LEVEL V (5) GENERAL POPULATION: 890 PEOPLE

Level V units are the most restrictive “general population” units. These units are not considered segregation necessarily; however, people in Level V typically remain in cell for 23 hours per day, and have limited access to programming and recreation.

MENTAL HEALTH PROGRAMS: 102+ PEOPLE⁸

Acute mental health units, secure status residential treatment programs, crisis stabilization units and the START Program are various programs designed for people with severe and persistent mental illness. While these programs are intended to be therapeutic, people in these settings are basically treated like level IV and V prisoners and receive almost no privileges - solely because of their diagnosis. They typically only get 2 hours out of cell, do not eat communally with others, and have limited showers, phone calls and personal property.

OBSERVATION CELLS: 26 PEOPLE⁹

People may be placed in an observation unit if they are at high risk of harming themselves, such as someone who is suicidal or at high risk of injury. Despite the deleterious effects of solitary on one’s mental health, they are placed alone in an isolation cell, often fed “food loaf” and forced to wear a knee-length suicide gown, known as a “bam bam suit.”



3,211

PEOPLE IN SOLITARY

Spend more than 20 hours a day
in their cell in Michigan prisons

65%

RACIAL DISPARITY

Sixty-five percent of people in
solitary confinement are Black

47%

PROLONGED ISOLATION

Forty-seven percent have been
isolated for more than 2 years

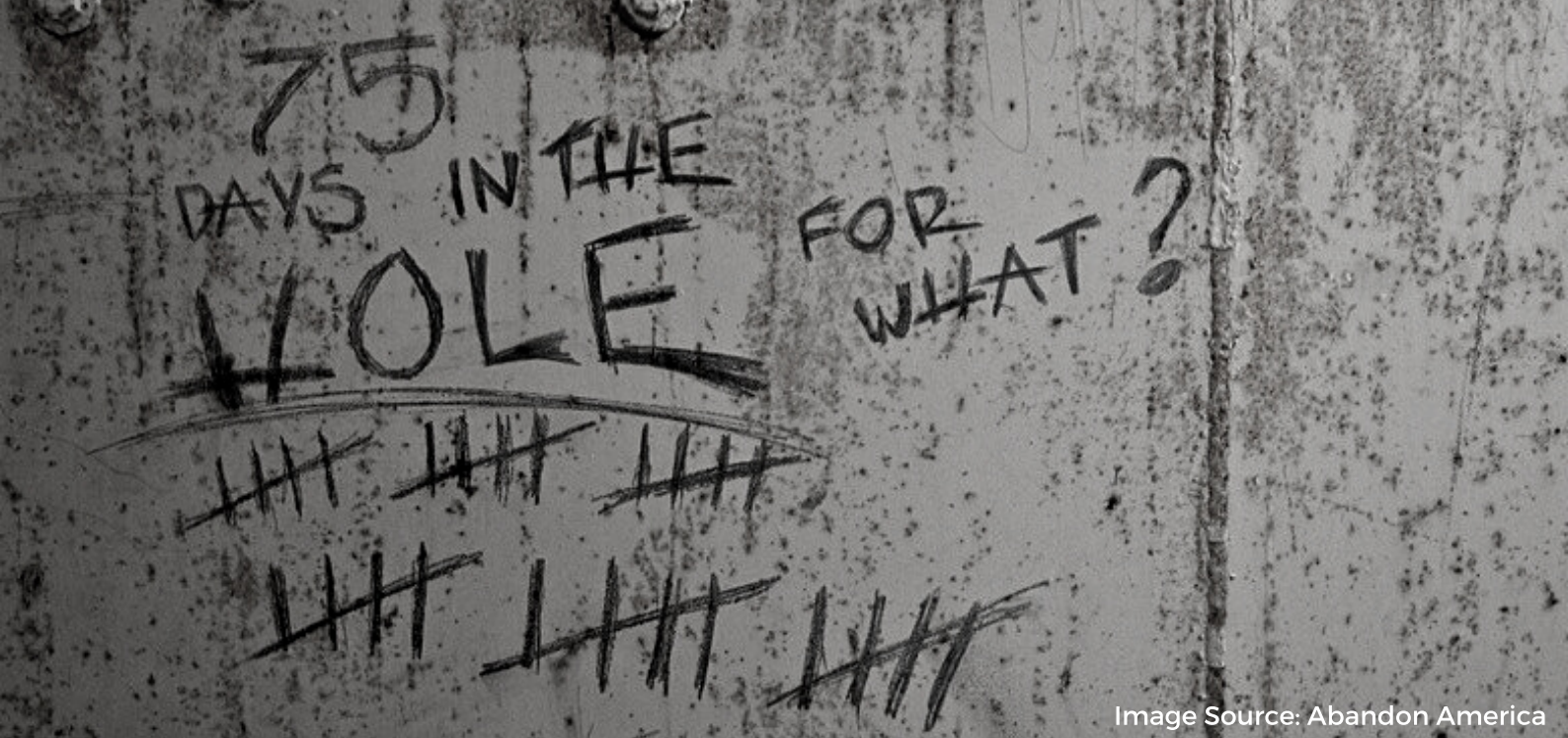


Image Source: Abandon America

THE SOLITARY EXPERIENCE

As of June 2020, the Michigan Department of Corrections reported that 3,211 people were placed in some form of isolation.¹⁰ Among those in administrative segregation and Level V cells, approximately 20 percent have been in for 6-12 months; 32 percent have been in for 1-2 years; and a shocking 47 percent have been in isolation for more than 2 years, including 11 percent who have been isolated for 5-20 years!¹¹ This is in stark contrast to the international guidelines known as the Mandela Rules, which state that “solitary confinement may only be imposed in exceptional circumstances, and “prolonged” solitary confinement of more than 15 consecutive days is regarded as a form of torture.”¹²

“The United Nations Committee Against Torture has long condemned the excessive use of harmful isolation practices in U.S. prisons. During an investigation into Connecticut prisons in February 2020, human rights expert Nils Melzer revealed that the Connecticut Department of Corrections “appears to routinely resort to repressive measures, such as prolonged or indefinite isolation, excessive use of in-cell restraints and needlessly intrusive strip searches... There seems to be a state-sanctioned policy aimed at purposefully inflicting severe pain or suffering, physical or mental, which may well amount to torture.”

Families gave a similarly dismal picture when asked to describe their loved one’s experience in solitary confinement in Michigan. For the safety of those inside, no names or identifying characteristics have been included.



IN MICHIGAN, PEOPLE IN SOLITARY REMAIN IN THEIR CELLS FOR 22-24 HOURS A DAY.

When someone is in segregation, they never see other people except through the food slot or while walking to the shower or yard. They are permitted one hour a day outside, referred to as the “yard,” where they are placed in a caged area alone. They are allowed three 10-minute showers and one 15-minute phone call per week, if they are permitted phone privileges.

“They put him in an outside caged area with a basketball hoop but no ball.”

There is almost no educational or rehabilitative programming.

Although the MDOC segregation policy states that “all prisoners shall be provided with property, program, and activity access,” families unanimously agreed that meaningful programming was not available to their loved ones in solitary. Some prisoners such as those designated as “security threat group II” are not even permitted to borrow books from the prison library.¹³

“Each time he has been in there he had nothing and just sat there and waited.”

Families have watched helplessly as their loved one's mental health deteriorates in solitary

Families described their loved ones as being stressed, unstable, losing comprehension of their surroundings, having delusions and hallucinations, eating paint chips off the walls, having marked changes in handwriting and speech, self-mutilating, and being diagnosed with depression, anxiety, panic, mania, paranoia, schizophrenia, rage, and post-traumatic stress disorder. Solitary can also cause mental illness in people with no prior diagnoses or cause them to exhibit symptoms typically associated with schizophrenia and psychotic disorders.¹⁴

“He has nothing to do in there so he goes crazier and bad stuff happens.”

“They don't request his mental health records. I tried to tell them his medical history and what hospital he was in but they won't listen to me. They are setting him up to keep failing.”

All privileges may be withheld and possessions are often lost.

People in segregation are permitted only a small list of personal items, such as hygiene products, state-issued clothes, bedding, and reading and writing materials. Over 90 percent of family respondents reported that their loved one was deprived of their personal property while in segregation; 47 percent noted paper restriction; and 41 percent said mail or reading material was withheld. They also described having televisions and music players taken away and items that had gone missing, including eye glasses, tablets, books, artwork, and photos of loved ones.

Many people who are in segregation are also sanctioned with “loss of privileges” (LOP). When this occurs in general population, people can be prevented from accessing one or more privileges, such as use of the day room, exercise facilities, group meetings, out-of-cell hobbycraft activities, kitchen area, yard, general library, movies, music, radio, TV, leisure time, telephone, visits, or e-mail kiosk.¹⁵ Typically, all of these privileges are revoked at one time.¹⁶

Although the policy states that LOP must be limited to 60 days, many families reported that their loved

one had continuously lost all of their privileges for months or even years at a time.

“There is real emotional damage when they find their property has been stolen.”

Deteriorating physical health is a significant concern.

A number of families reported that their loved one lost startling amounts of weight from not getting enough food and not receiving medical attention in a timely manner. Multiple families reported that their loved one did not receive prescribed medication for weeks at a time, even after alerting the warden and healthcare to the issue. Over forty percent of families felt that their loved one was denied access to medical attention, often because the custody or healthcare staff thought they were being manipulative or “faking” an illness. Unfortunately, this type of dismissive culture breeds neglect and a lack of urgency when someone is experiencing a real medical or psychiatric emergency.

“We called several times expressing the need for medical and were told repeatedly that he was physically ok. He died of dehydration.”

Food and water restriction was noted as a common form of punishment.

Over a quarter of family respondents reported that their loved one was either denied meals entirely or given “food loaf,” a disgusting concoction of blended food cooked into a loaf. Another one-third of family respondents stated that their loved one had the water deliberately turned off. While MDOC policy states that “prisoners shall not be denied adequate health care or meals,” they may be placed on food or water restrictions in order to manage disruptive behaviors.¹⁷ Healthcare staff are required to be contacted to monitor if someone’s health is at risk during these restrictions; however, court records revealed that in the starvation death of Anthony McManus, for example, the nurses described being so “overwhelmed by the number of prisoners for which they were responsible that... they were not obligated to do much more than look for a breathing body in the cell.”¹⁸

“For the first week, almost two, the guards wouldn’t feed me or let me shower. What they would do is stop at my door and ask me ‘did I want to eat or shower’ and then keep going. Going through that, all I thought about was death.”

“The officers would place my food on the slot and when I reached to get it, they would dump the tray on the floor... The officer let me know that I had to eat my food at my own risk. They were spitting in my food, and I would find chewed tobacco under my potatoes or vegetables.”

Since that time, numerous inmates have died of dehydration and heat exhaustion when their water was turned off. Even so, MDOC policy does not require that healthcare staff be notified if someone’s water is turned off unless they have not been drinking for 24 hours.¹⁹ While staff are required to periodically offer water, they do not need to ensure that the person drinks it.²⁰

Perhaps one of the most oppressive features of solitary is the sensory overload or deprivation

While some solitary units are eerily silent, over a third of family respondents reported that seg units are incredibly loud, with continuous shouting and yelling. Lights may be left on all the time, such that people have a hard time sleeping. One family recounted a story in which the officers thought it was funny to turn the lights on for over an hour during the 11:00pm and 4:00am bed counts. Another family shared a story about how the intercom had a buzzer which the officers would repeatedly push for minutes on end.

The majority of families felt that their loved ones received degrading and dehumanizing treatment.

They described some of the correctional officers as well as mental health and nursing staff, as hardened, demeaning, threatening, and, in some cases, abusive. Their loved ones described being told they were “ugly, worthless, non-human, and that their life has no meaning.” Some families also believed their loved one was targeted for retaliation or bullying, while others said their loved one was mostly ignored, receiving no attention even when they needed help.

““My son is treated like a dog. I have no idea how he has made it this far.” “It has destroyed his ability to trust the guards.”

It is important to note that a few families said their loved one were treated fairly by the officers, mental health and nursing staff, describing them as “polite and upright and caring.”

Physical and chemical restraints or tasers appear to be used regularly as a form of physical management or punishment.

Forty-seven percent of family respondents reported that their loved one experienced hogtying, “therapeutic” restraints, or top of bed restraints, sometimes for 24 hours. Nearly thirty percent of family respondents said that their loved one had been tasered. Eighteen percent of family respondents reported use of chemical agents, like gas or pepper spray. While these strategies may be employed as a means of physical management, they are traumatic and could be life-threatening.

“I was told by my son that an officer put his knee on his neck.”

“One time my brother was restrained and tied down to a bed for an entire week and was forced to urinate and defecate on himself.”

Over fifty percent of family respondents noted issues with extreme temperatures.

During the summer months, cell temperatures can rise to over 100 degrees. Fans are provided on the unit but that does not help circulate air past the steel doors. They are not even permitted to have their food slot open to get a sliver of fresh air when the prison is under a heat advisory. With windows unable to open, people inside describe the feeling of roasting in their cells. Temperatures can also be incredibly cold in the winter months. Families state that their loved ones were freezing, with minimal clothing supplied and no warm blanket.

Because of the harmful conditions, people in solitary are at extreme risk for self-mutilation and suicide.

The number of suicides in Michigan segregation cells is currently unknown; however, a study of New York's jail system found that although only 7.3% of people were placed in solitary confinement, they accounted for over half of all self-harm and suicide attempts.²¹ Some of this disparity could be attributed to mental illness being exacerbated while in solitary, but also to the fact that extreme isolation takes away coping mechanisms that they've learned to rely on, such as calling home, having conversation, or watching TV.²² Without these strategies, feelings of hopelessness and despair may make it feel like there is no other way out.

"Imagine getting a letter from your son, who has always been loving, smart, caring, helpful, non-violent and well loved by many, saying that he wants to end it all. I'm scared he will commit suicide."

"He's begging to get out so he hurts himself to get out."

"I was so mentally exhausted from being in segregation that I put a razor to my wrist... and wanted to cut, but a smiling image of my mother popped into my head so I put the razor down."

"Some men just can't take it and they either die in there or get so mentally wrecked it would be hard to get over, if at all."

"I'm terrified that he will lose his fight to live!"

"He was forced to wear a bambam suit. He felt too exposed to walk past other prisoners in order to shower. No shower meant longer solitary because he did not meet the cleanliness standards."

MDOC SEEKS TO REDUCE USE OF SEGREGATION

In its 2019-2022 strategic plan, MDOC stated its commitment to reducing the use of segregation by June 30, 2019 and developing safe alternatives to segregation housing. It assigned the Deputy Director of Operations to oversee a plan that monitors the use of segregation and specialized housing.²³ The most well known effort was the Incentives in Segregation program, piloted at Alger Correctional Facility in 2009. Initially, this 6-stage step-down program showed great promise, decreasing the use of segregation by 20% and significantly reducing critical incidents and rule violations.²⁴ However, the program has come under scrutiny because there are no clear policies or timelines. Prisoners who reach higher levels may be subjectively returned back to level 1 and forced to start over.

DIVERTING PEOPLE WITH MENTAL ILLNESS

MDOC's Security Classification Committee, which determines segregation placement, is required to take a prisoner's need for mental health services into consideration when deciding the most appropriate placement for them. The MDOC's Segregation policy is clear that a person "showing any signs of medical or mental decompensation shall be immediately referred for evaluation."²⁵ However, one family explained that,

"While there were some mental health staff that cared and communicated with us, often they stated their hands were tied, that custody trumped getting him better treatment and out of solitary confinement."

Policy does, in fact, prioritize security over mental health treatment and custody staff are not required to release someone who needs mental health treatment that cannot be accessed in segregation.²⁶

In April 2017, MDOC Director Heidi Washington created a workgroup to reform the use of long-term segregation and end the use of segregation for people with serious mental illness. The START program was piloted in 2018 in two prisons as a way to divert people with serious mental illness who exhibit problem behaviors that would otherwise land them in administrative segregation.²⁷

"The START program is basically solitary with a different name."

Unfortunately, the START program has not lived up to its therapeutic ideals, mimicking the 20+ hours in cell each day for the people who reside on this unit. Like Incentives in Segregation, the START program is based on levels, in which prisoners can, theoretically, earn privileges as they increase in level. People who are on level 1 must earn even their personal property and phone calls, both of which they would be entitled to if they were in administrative segregation.



CORRECTIONAL OFFICER SAFETY AND MENTAL HEALTH

Correctional officers who work in solitary units may also experience harmful effects as a result of secondary trauma. In July 2019, MDOC commissioned a study to examine the well-being of correctional officers, finding that “their well-being is inextricably linked to the safety and quality of operations at MDOC.”

Although this study was not specific to officers on solitary units, the findings were shocking:

Custody staff, especially those working in facilities housing men, had significantly higher rates of

Major Depressive Disorder (25%),

Generalized Anxiety (50%),

Post-traumatic Stress Disorder (41%),

Alcohol Abuse (25%), and

Suicidal Ideation (9%)

than compared to first responders, the military, or the general population.²⁸ Of greatest concern is that 34 respondents revealed that they were actively planning to complete suicide, prompting an urgent need for mental health support.



COMMUNICATION WITH LOVED ONE AND STAFF

“As time has gone on, many have moved on with their lives and don't communicate with him now. His support system has dwindled to just 5 people over the last few years.”

“It has been hard for his brother and him to maintain the closeness he would like. His older brother has his own life that is very busy and he often misses the phone calls.”

“When my loved one was allowed visitors, he was taken to a room for a no contact visit. He was in shackles and humped over (because the shackles were too short) so he could get his ear to the phone. It hurt his back. It was so degrading.”

“You are never told anything. You just gotta sit and wait to hear from them and hope nothing bad happened.”

“No one would either return my phone calls or they flat out refused to tell me any information.”

“They do not release information on why or how long they are locked down.”

“I am his POA (power of attorney) and emergency contact and they still would not tell me anything.”

“Not being able to communicate with me or his family took a toll on him.”

“At one time. I was treated with kindness. The nurse told me she was calling because she knew my son needed outside communication.”

“It's scary not being able to speak to him. My anxiety was at an all time high whenever he was in segregation.”

“My son asked us to stop visiting for a while because the shackles were so tight and cutting into his skin, causing his ankles to bleed.”

“I sit and wonder if he is dead because I don't receive my daily jpay message.”

Families are not informed when a loved one is placed in solitary confinement, nor updated on their condition while in isolation.

When a loved one is placed in solitary, contact becomes extremely limited. Families who are used to hearing from their loved one every day, or receiving regular emails, are suddenly cut off. The department does not have any policies or procedures to inform families when a loved one is placed in segregation so they may learn about their loved one's reclassification from another inmate or after numerous attempts to call staff. Some families have been told that it is against MDOC policy to share information with family members, even after having their loved one sign a release of information.

Families are also not regularly informed by staff about what is happening to their loved one while in isolation, or given any indication of how long they will be there. Families were especially concerned about not being able to have regular contact with loved ones with known physical and mental health issues.

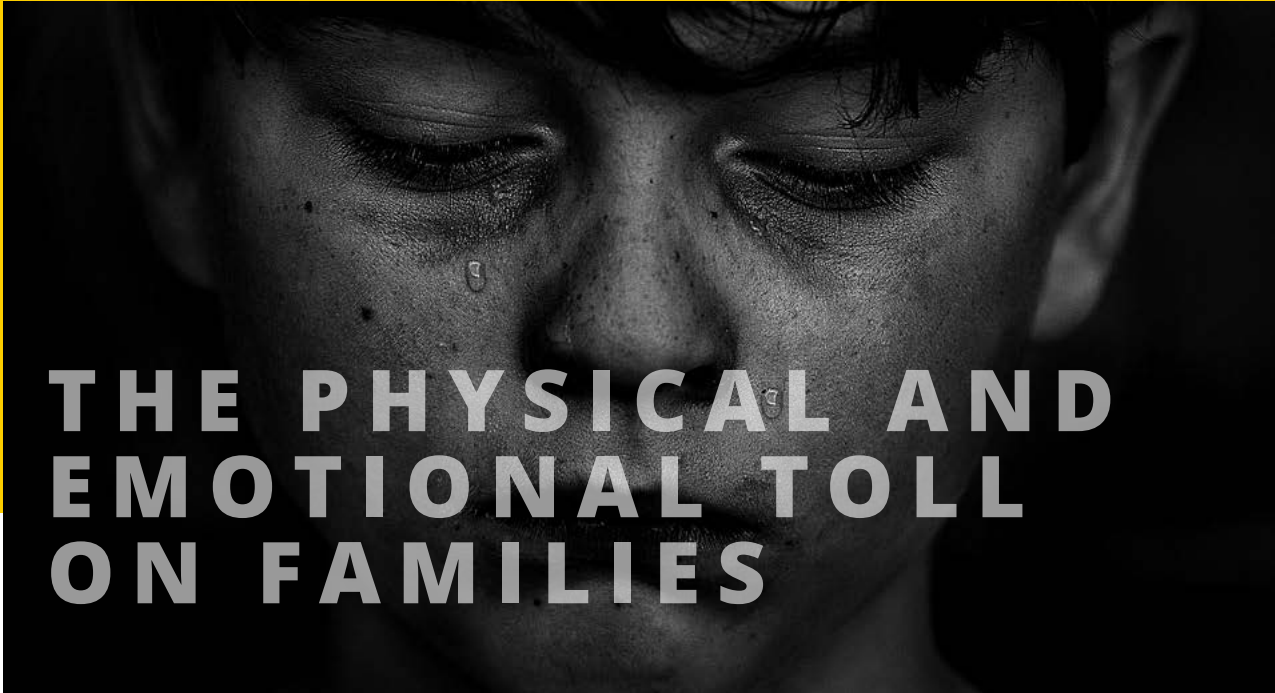
Eighty-five percent of family respondents reported that they were denied phone calls or had visiting restrictions while their loved one was in solitary.

MDOC policy states prisoners are permitted one 15-minute phone call each week, but most families said that phone calls were few and far between while in solitary.²⁹ People on disciplinary sanctions, which is not uncommon in segregation, can only have one 15-minute phone call every thirty days.



Some families reported that their loved one was simply denied use of the phone, even when they were not on any sanctions. For both those inside and outside, these phone calls are critical to uplift spirits, decrease anxiety, and allay concerns about safety. Families conveyed that it is difficult to maintain closeness given the barriers to communication and loss of privileges. It is especially hard for children who can only speak to their parent for a maximum of 15 minutes each week.

Many families reported challenges with visiting their loved ones given the limited visiting hours. In some prisons, segregation visits would be one day a week for just two hours, while other prisons might have two day choices with a 4-5 hour block of time for visits. If their loved one was placed in the Upper Peninsula, for example, they would need to drive across the state not knowing if they would make it in time. Visitations may also be revoked altogether as 'loss of privilege.'³⁰ Even people who have guardianship over their loved one in prison may not be permitted in for visits.



THE PHYSICAL AND EMOTIONAL TOLL ON FAMILIES

PEOPLE IN PRISON ARE NOT THE ONLY ONES TO EXPERIENCE THE DELETERIOUS EFFECTS OF SOLITARY ON ONE'S MENTAL HEALTH.

Nearly all family members said that they were extremely anxious, scared, and worried for their loved ones' safety and wellbeing while in segregation. For some, this constant state of worry led to diagnosed anxiety disorders, depression, panic attacks, and deep loneliness. A number of family members have sought their own mental healthcare to deal with the overwhelming anxiety and fear that comes with enduring solitary on the outside.

FAMILIES REPORT VARIED PHYSICAL HEALTH CONDITIONS RELATED TO STRESS.

Family members are literally "worried sick" over their loved ones in segregation, experiencing stress-related physical conditions such as arrhythmia, chest pains, cracked teeth, TMJ, insomnia, nightmares, and an inability to concentrate or work.

"I have very high anxiety, extreme depression, loss of faith, my whole life has been affected daily, I am either numb or cry all the time."

Anytime he is even a couple hours past his normal calling time I start to have panic attacks wondering if he has gotten hurt again."



"I AM NOT THE PERSON I WAS. I AM FOREVER CHANGED."

"He has three girls that cry for him and have depression over not hearing his voice."

"My kids are appalled by how their sister is being treated."

"My other son and daughter cry everyday. It has affected their mental states and their everyday life. No child should have to bear any of that."

"It made our son depressed to the point of having to be put on medication."

"I'm honestly worried sick, I can't eat, sleep, I can't even be happy in my daily life."

"I was constantly breaking down, scared if he was ok or not."

"Both my kids cry daily on how much they miss their brother."

"I've been in constant fear for 23 years."

"It's the kind of worry that keeps you up at night. You can't sleep."

"It stresses us all out to the point of being physically sick and depressed."

"I stopped eating and lost 60 pounds."

"It's hard for me to concentrate at work. I am constantly worried and anxious."



FAMILIES CONSISTENTLY REPORT FEELING FRUSTRATED, ANGRY, AND HELPLESS

It's difficult knowing that their loved one's mental health was deteriorating and there was nothing they could do to help. Families are such an important resource to help identify strategies to de-escalate problem behavior; however, many families said they feel ignored or that their input is unwelcome.

"I know what shot works best to stop the voices in his head but they won't listen."

ANXIETY AND DEPRESSION AMONG CHILDREN WAS COMMON.

The impact of solitary on children with an incarcerated parent is particularly devastating. Although the majority of people in segregation are male, there is a growing number of women who are incarcerated, leaving many children without their primary caregiver.³¹ This separation can damage the parent-child relationship, especially given the restrictions on visits and phone calls. As a result, many children suffer from anxiety and depression when their parent is in segregation.

"My mother and his daughter have often contemplated suicide."



THE LONG TERM IMPACTS OF SOLITARY

While families are eager to have their loved ones get out of solitary, they expressed concerns about their ability to adjust back into the general prison population. The extent of post-traumatic effects of solitary vary but often affect one's ability to engage with others, making them feel paranoid, mistrusting, and short-tempered.³² Isolation also makes people feel skittish in large groups in close proximity. The impact on short-term memory, inability to focus, and lack of concentration makes it difficult to do day-to-day activities. Unfortunately, these behaviors often appear as if they are willfully ignoring rules or being disruptive, which might make someone a target of prison violence or land them back in segregation.

“In the end, they’re making them unfit for the real world and setting them up for failure.”

Unfortunately, the deterioration to one's mental health during solitary may also impact their ability to safely interact with other people when they are released to the community. Research shows that people who experienced solitary confinement while incarcerated are significantly more likely to meet criteria for post-traumatic stress disorder after exiting prison.³³ Furthermore, people who experience solitary confinement have higher rates of recidivism than those who do not, typically attributed to the psychological damage inflicted while in solitary.³⁴ Once returned to the community, people who have spent time in solitary confinement are 24% more likely to die within the first year, either by suicide (78% more likely), homicide (54% more likely), or opioid overdose (127% more likely).³⁵

“PTSD from prison and solitary confinement makes it harder to transition back to community.”

“I worry that he won’t know how to interact.”

“He will be aggressive and mentally unstable.”

“Even when he did get out for a while, he was depressed and wanted to isolate.”

DEATHS IN SOLITARY

2002

OZY VAUGHN

Died of dehydration after being placed in an observation cell at Riverside Correctional Facility. Although it was known that Ozy's medication for schizophrenia interfered with his ability to regulate body temperature, he was left in a cell that reached over 90 degrees. During this time, he was observed babbling nonsensical words, standing in one position for hours on end, appearing to be in a catatonic state, excessively sweating, and vomiting.³⁶

2002

JEFFREY CLARK

Died of dehydration while in solitary at Bellamy Creek Correctional Facility. Even though the heat index was over 100 degrees, the water to his cell had been turned off and he resorted to drinking toilet water. Jeff's sister stated that reports showed "he had his mouth up against the plexiglas window, begging and pleading for water and air."³⁷

2005

ANTHONY MCMANUS

38 years old, died of starvation while in solitary at Baraga Maximum Security Prison. In an effort to control his "bizarre" behavior, staff used a chemical spray on him and restricted his food and water. He became "extremely undernourished," going from 140 pounds to just 75 pounds in five months, with one of the nurses comparing his appearance to a "concentration camp prisoner."³⁸

2006

TIMOTHY SOUDERS

Age 21, died of complications of hyperthermia (overheating) while chained to a concrete bed for four days in a solitary cell at Southern Michigan Correctional Facility. Souders, who suffered from bipolar depression, was sent to solitary for taking a shower without permission. While in solitary, he broke a stool and flooded the sink in his cell, at which point officers placed him in chains, a practice called "top of bed" restraints, for 12-17 hours at a time. When Souders began exhibiting erratic behavior, mental health professionals were not called.³⁹

DEATHS IN SOLITARY

2014

DARLENE MARTIN

Placed in solitary at Huron Valley Women's Correctional Facility, where she exhibited erratic behavior and auditory hallucinations. Court records reveal that, "she was saturated with filth and her feet were significantly pruned from standing in her own sewage, urine and excrement." Although she needed urgent medical treatment, the water to her cell was shut off and staff continued to inject her with sedatives, without checking her vital signs.⁴⁰ Dehydration caused her to experience respiratory arrest, dehydration, liver and renal failure, and a brain injury, leading to her eventual death.

2014

SABRIE ALEXANDER

27 years old, died in a solitary observation cell at Huron Valley Women's Correctional Facility. Sabrie suffered from numerous medical conditions, most notably an aggressive seizure disorder and bi-polar disorder.⁴¹ According to her mother, Sabrie suffered 100 seizures in the two days leading up to her death but her repeated screams for help were ignored.

2019

JONATHAN LANCASTER

38 years old, died of dehydration while strapped to a restraint chair in a solitary cell at Alger Correctional Facility. He was placed in segregation after exhibiting bizarre behaviors, consistent with his diagnoses of bipolar disorder and schizophrenia. Reports show that he exhibited paranoia that he was being poisoned, stood with a blank stare for extended periods of time, crouched in a fetal position, refused meals, fluids and medications, had audio and visual delusions, and insomnia. Despite repeated calls from his family begging for him to receive help - including on the day of his death - Jon lost 50 pounds in the two weeks, ultimately dying of dehydration.⁴²

2020

ROBERT PEARSON

Died by suicide in solitary at Marquette Branch Prison. According to his family, Robert had repeatedly been requesting to see a psychiatrist because he was experiencing a mental health breakdown. Rather than responding to his psychiatric emergency, the staff called him names and wrote a violation for "disobeying a direct order," and took him to the hole. He hung himself after being in segregation for 7 days.



RECOMMENDATIONS

The damage caused by solitary confinement cannot be understated. Family members sit in anguish as their loved ones are caged in a prison inside a prison. When they are able to communicate with them - either by limited phone calls, non-contact visits, or letters - they hear of degrading treatment, harsh conditions, and thoughts of suicide.

Families are calling upon the Michigan Department of Corrections to end this archaic and inhumane practice and join other states that are creating safer alternatives that can achieve security without causing irreparable harm.

The changes that are being proposed are not revolutionary. Increased out-of-cell time, more recreation and therapeutic programming, and meaningful connection to family members and other human beings are simple changes that would be transformative in the lives of those impacted by solitary confinement. On a broader scale, improved monitoring, oversight, and systemic reform is clearly needed. Effective alternatives to segregation do exist and families are eager to help develop these solutions in order to make the prisons and communities safer.

1. Eliminate indefinite or prolonged isolation in all its forms and for all people.

Short-term isolation should be limited to 15 days or less and only if absolutely necessary to protect the safety of incarcerated persons and corrections staff. Even during this time period, people should have access to consistent and meaningful therapy, programming, and at least 4 hours out-of-cell time, if not more, each day.

2. Ban isolation for vulnerable populations,

especially youth ages 21 and younger, people with disabilities, elders over the age of 55; pregnant women and new mothers; or any individuals who have medical or mental health issues that might be exacerbated by isolation. Segregation should be prohibited as a form of protective custody for vulnerable groups, such as individuals who identify as lesbian, gay, bisexual, transgender or queer, and should never be used as a mandatory punishment due to conviction of a specific crime.

3. Invest in officer training related to mental health first aid and de-escalation techniques.

In many instances, segregation could likely be prevented altogether if de-escalation strategies were employed. Rather than relying on chemical sprays and restraints, custody and mental health staff should be equipped with the tools to diffuse problem behavior before it becomes dangerous and appropriately respond to psychiatric emergencies.

4. Replace the practice of isolation with humane, safe, and effective alternatives.

Graduated sanctions and segregation alternatives, such as short-term de-escalation cells and therapeutic cells can provide the same benefit of a “time out,” without the deleterious effects of isolation on mental health. A therapeutic step-down program would also help people safely transition back to general population.

5. End the use of restraints,

such as hogtying, top of bed restraints, and chemical sprays. Not only are these practices traumatic and painful, they can also be deadly. Alternative non-violent interventions should be utilized to ensure the safety of both the incarcerated person and custody staff.

6. Inform, support and encourage connection to families with a loved one in solitary.

Each solitary unit should appoint a family liaison who informs families when their loved one is sent to segregation, updates them on their condition, and seeks input about treatment needs. People in solitary should be allowed regular calls and visits to maintain family connections. The frequency and duration of visiting times should be extended; contact visits should be permitted, especially with children; and people should be allowed to remove shackles during non-contact visits.

7. Do not withhold food or water nor allow people to overheat in segregation cells.

Far too many people in segregation have died from starvation, dehydration and other inhumane conditions. Recognizing these tragedies, new procedures should be put in place to more closely monitor food and water consumption and document instances in which people are refusing to eat or losing weight. Likewise, new policies must be instituted to ensure that cell temperature does not exceed 80 degrees, including use of fans and air conditioning, or opening doors or food slots.

8. Improve access to trauma-informed health and mental health services.

Qualified clinicians should do a comprehensive review of the individual's medical and mental health records and, with permission, seek input from the family. Weekly checks should be conducted by healthcare professionals and trauma specialists to evaluate their well-being and readiness to return to the general population. Individuals who exhibit signs of self-harm or suicide should immediately be removed from isolation.

9. Limit loss of privileges.

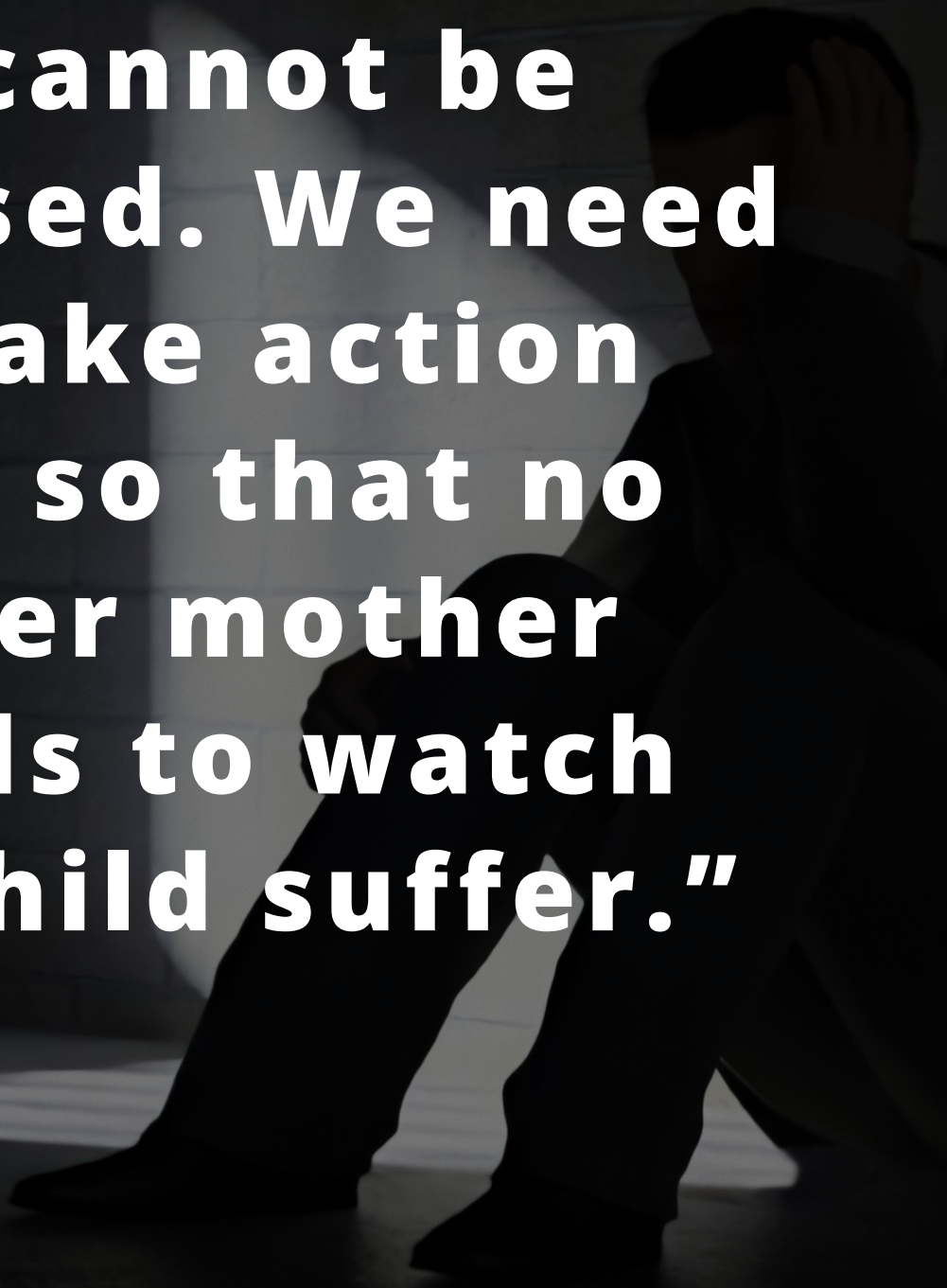
People in isolation should be allowed all of their personal belongings, rather than having to earn them based on good behavior. Likewise, people should have access to items to help keep them occupied, such as television, music, or tablets. Loss of privileges should be limited to one or two items so that people do not wind up losing all privileges for years and years.

10. Ensure transparency, accountability, and independent oversight

in the use of isolation and in conditions of confinement in general. An independent oversight committee that includes families should be established to respond to concerns and monitor trends in the use of segregation.

“The damage that is done in solitary cannot be undone.

It cannot be reversed. We need to take action now so that no other mother needs to watch her child suffer.”



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Suffocating
Loss of faith
Inhumane
Scary Anxious
Helpless
Traumatized
Torture
Upset Awful
Sad
Devastating
Desperate Angry
Hell
Isolated
Frustrating
Unfathomable
Disturbed
Worry