Torturing Mentally Ill and Juvenile Prisoners: An Examination of Michigan’s Administrative Segregation Policies

INTRODUCTION

Non-violent, mentally ill, and juvenile prisoners are not the typical prisoners one would associate with solitary confinement. But in Michigan prisons, mentally ill and juvenile prisoners have been subjected to Administrative Segregation in what the State describes as a “safety” placement. This Note argues that Michigan should reform its Administrative Segregation and offer better alternatives. The scope of this Note focuses specifically on mentally ill and juvenile prisoners, but at times will reference or discuss general prison population in relation to the other two classes of prisoners.

Part I discusses the history of solitary confinement. In order to understand how Michigan’s system came to be, it is imperative to understand how solitary confinement began. The first section introduces how solitary confinement started in United States prisons, while the second section briefly highlights Michigan’s history with the practice.

Part II analyzes Michigan’s policies regarding solitary confinement. This part illustrates the numerous policies in place, the different ways prisoners can be placed into and released from segregation, as well as Michigan’s initial steps toward reform.

Part III discusses the harmful psychological and physiological effects solitary confinement has on prisoners. This part focuses directly on mentally ill and juvenile prisoners, and exemplifies the specific effects suffered by each population while in Administrative Segregation.

Part IV highlights two major state reforms to solitary confinement practices: New York and Colorado. Each is discussed in detail to show the major steps each has taken in setting the benchmark for reform platforms. This section also addresses the ways both states began their reform and why the chosen method has an effect on the state’s ability to control the reform outcome.

Part V outlines how Michigan should reform its segregation policies to better reflect the effective policies referenced in Part IV. The reform is proposed in two ways: (1) general reforms to all Administrative Segregation practices; and (2) specific reforms targeted at mentally ill and juvenile prisoners. Lastly, this Note discusses additional steps the Michigan Department of Corrections needs to take to ensure the long-term success of the reform.

1. Michigan refers to solitary confinement as “administrative segregation,” but both terms have the same meaning and will be used interchangeably throughout this Note.
I. HISTORY OF SOLITARY CONFINEMENT

A. United States

In 1829, solitary confinement was first introduced to the United States at Eastern State Penitentiary in Pennsylvania as an “experiment” to build a true penitentiary—one “designed to create genuine regret and penitence in the criminal’s heart.” The Quaker-inspired method was strict, forced labor, which prevented distractions by keeping prisoners isolated. Cell blocks revolved out around a central surveillance rotunda. Each cell had central heating, flushing toilets, and running water—none of which the White House even had at the time. The goals of the individual cell design were to encourage spirituality and repentance. To accomplish said goals, each cell door was slightly smaller—forcing the prisoner to bow when coming into his cell—and the sky lit cell only offered prisoners light from the heavens. Within a decade of Eastern State being built, over 300 prisons around the country and world adopted what they deemed the Pennsylvania system.

Early results, however, did not yield the result many hoped to see with the Pennsylvania System—repentance. Rather, many prisoners went insane, committed suicide, or were unable to function later in society. These results were captured in 1842 by Charles Dickens after his visit to Eastern State. He wrote, “I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any [other] torture of the body . . . as a . . . punishment which slumbering humanity is not roused up to stay.” But Eastern State was not the only prison with an isolation system, and Charles Dickens would not be the last person to report such findings surrounding solitary confinement.

In re Medley, in 1890, was the first major challenge to solitary confinement to reach the Supreme Court. The issue before the Court was whether it was constitutional to keep a prisoner sentenced to death in solitary until his death sentence was carried out. While discussing the peculiarities of solitary, the Court found “[a] considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition,


3. Id.

4. Id.

5. Id.

6. Id.

7. Id. (as opposed to the Auburn System which was previously in place across the country).


from which it was next to impossible to arouse them...others became violently insane[,]...committed suicide[,]...and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.”

The Court held the prisoner’s constitutional rights were violated, but limited its holding to the prisoner in that case. Thus, despite the findings of Charles Dickens and the Supreme Court, solitary confinement remained a suitable punishment; and Eastern State Penitentiary would maintain the practice until its closure in 1971.

Prisons in the 1980’s took a step beyond Eastern State and created the “super-max” prison. A super-max prison is a control unit within a prison which consists of twenty-three-hour a day lockdown and no contact with others. Moreover, these units are a permanent placement for prisoners to finish out or serve their sentence. The objective of these prisons is to house the “worst-of-the-worst”—those prisoners posing the greatest threat to the prison population or national security. The actual prototype and early standard for super-max prisons started in 1934 at Alcatraz Island, but the idea for twenty-three-hour a day lockdown did not come until 1984.

In 1983, two Federal correctional officers, in separate incidents, were murdered by prisoners at a Federal Penitentiary in Marion, Illinois. This prompted the warden to put the prison in twenty-three-hour lockdown to ensure safety throughout the facility. Marion created the benchmark for the super-max prison, and by 1996 at least fifty-seven super-max prisons operated across more than thirty states. As a result of this movement, the Director of the Federal Bureau of Prisons called for a new type of prison unit to deal with inmates who “show absolutely no concern for human

10. Id. at 168.
11. Id. at 173–74.
15. Id.
16. Id.
17. Id.
18. Id.
life.” 21 These prison units would become known as Special Housing Units, or “SHU.” 22

Today, ADX Florence in Colorado, also known as the “Alcatraz of the Rockies,” is the only true “super-max” prison still in existence. 23 The Colorado Penitentiary has housed notorious inmates such as: Terry Nichols, accomplice to the Oklahoma City Bombings; Richard Reid, the “shoe bomber”; and most recently, the Boston Bomber, Dzhokhar Tsarnaev. 24 However, as this Note will discuss, numerous states still have Special Housing Units which function similarly to ADX Florence. 25

B. Michigan

Michigan Department of Corrections (“MDOC”) does not have as long of a history as the federal corrections system. Nonetheless, Michigan has been inspired by the federal system. 26 It is not exactly clear when Michigan began to use solitary confinement, but litigation suggests the practice has been around since at least the 1980’s. 27 Moreover, the litigation shows MDOC has been placing prisoners with mental illness in solitary confinement for just as long. 28 A recent report shows the daily average number of prisoners with mental illness or developmental disorders in segregation, between 2007 and 2015, ranged from thirty-five to ninety-six prisoners a day. 29 The statistics on juvenile prisoners in confinement, however, are not as well documented due to a lack of policies within the MDOC. While there is currently no prohibition in state law, or MDOC

22. Id.
25. See infra Section IV.
26. See infra Section II.
29. MICH. DEPT’T OF CORR., ADMIN. SEGREGATION REPORT TO THE LEG., P.A. 59 of 2013, Section 925 (2013) (reported total number of days for prisoners with mental illness or developmental disorders, for the same time period, ranged between 12,775 to 34,979 days—equivalent to between 35 and 100 years—of confinement in a single year) [hereinafter ADMIN. SEGREGATION REPORT TO THE LEG.].
policies and regulations, against holding juveniles in Administrative Segregation, there is pending legislation which could change this.\textsuperscript{30}

II. MDOC POLICY SURROUNDING ADMINISTRATIVE SEGREGATION

The MDOC defines Administrative Segregation as "confinement for maintenance of order or discipline to a cell or room apart from accommodations provided for inmates who are participating in programs of the facility."\textsuperscript{31} MDOC’s policies suggest the goal or mission for Administrative Segregation is to promote prisoner rehabilitation.\textsuperscript{32} The purpose of that goal is to "limit that prisoner’s movement inside the institution" and "achieve effective administrative management, maximum disciplinary control, and individual prisoner protection."\textsuperscript{33} But limitations and disciplinary control depend on which unit of segregation a prisoner is sentenced.\textsuperscript{34}

MDOC Policy Directive 04.05.120 details three levels of segregation a prisoner may be placed into: (1) temporary;\textsuperscript{35} (2) punitive;\textsuperscript{36} or (3) administrative.\textsuperscript{37} This Note is only concerned with exploring Administrative Segregation in relation to mentally ill and juveniles. This is not to say mentally ill and juvenile prisoners cannot suffer harmful effects from the other two forms of segregation, but the immediate threat of danger is not present as it is in Administrative Segregation. Both temporary and punitive segregation can be used to punish prisoners for class 1 misconduct violations;\textsuperscript{38} but Administrative Segregation is used as a combination for safety and punishment.\textsuperscript{39}

\begin{itemize}
\item \textsuperscript{30} \textit{Infra} Conclusion.
\item \textsuperscript{31} \textit{Admin. Segregation Report to the Leg.}, supra note 29.
\item \textsuperscript{32} See Mich. Dep’t of Corr., Policy 01.01.100-Mission Statement (2011).
\item \textsuperscript{33} Mich. Dep’t of Corr., Policy 04.05.120-Segregation Standards, ¶ D (2010) [hereinafter Segregation Standards].
\item \textsuperscript{34} Id. at ¶ J–U.
\item \textsuperscript{35} Id. at ¶ J–K. Except in a limited number of situations, placement into temporary segregation is limited to 7 days. This form of segregation is used to remove prisoners from general population who are pending hearings or investigations for the prisoners’ safety, transfer, or class 1 misconduct violation. Id.
\item \textsuperscript{36} Id. at ¶ U. Punitive segregation is used to serve detention sanctions for class 1 misconduct violations. These cells are contained within the segregation unit but do not carry the same restrictive limits as prisoners classified in Administrative Segregation. There are parts of policy number 4.05.120 suggesting a prisoner could be held in punitive segregation for periods extending thirty days, six months, or even one year. See ¶ F.
\item \textsuperscript{37} Segregation Standards, supra note 33, ¶ L–T.
\item \textsuperscript{38} See Mich. Dep’t of Corr., Policy #3.03.105A, Attachment A p. 1–3 (class 1 misconduct violations include numerous tortious and criminal actions including attempt, accomplice to, and conspiracy to commit).
\item \textsuperscript{39} Segregation Standards, supra note 33, ¶ D.
\end{itemize}
A. How Prisoners Can Be Transferred or Reclassified to Administrative Segregation

The MDOC refers to Administrative Segregation as the “most restrictive level or security classification.” The decision to place an adult prisoner in Administrative Segregation is through either: (1) immediate transfer—when found guilty of class 1 misdemeanor; or (2) reclassification—if an MDOC official finds the prisoner’s behavior warrants segregation, irrespective of whether the prisoner was found guilty of a violation. The procedural threat to mentally ill prisoners is through the reclassification process, which allows the MDOC to transfer prisoners to Administrative Segregation without being charged with a class 1 misdemeanor.

A prisoner could be subject to reclassification if a correctional officer finds a prisoner’s behavior falls under one of the following:

1. is a serious threat to the physical safety of staff or prisoners,
2. demonstrates inability to be managed with general privileges,
3. is a serious escape risk,
4. is under investigation from an outside authority, or
5. refuses medical treatment for a communicable disease.

However, the procedure before any prisoner is reclassified to Administrative Segregation requires: (1) a Notice of Intent (“NOI”) to be filed; (2) a hearing to be conducted by the State Office of Administrative Hearings and Rules (“SOAHR”); and (3) a final review conducted by the Security Classification Committee (“SCC”). Nonetheless, even with this...
reviewing procedure, reclassification poses a serious threat to mentally ill prisoners because often times their behavior can be misidentified as a serious threat or an inability to be managed.

B. How Juveniles Can Be Transferred into Administrative Segregation

Juveniles are subject to these Administrative Segregation policies when they enter an adult facility. In Michigan, seventeen-year-olds are automatically considered adults for criminal offenses. Additionally, juveniles can be sentenced or transferred to an adult facility by: (1) automatic waiver—if the juvenile is fourteen years or older, and is convicted of one of eighteen “specified criminal offenses;” or (2) designation—if MDOC deems the youth poses a risk to others, or if the prisoner requires psychiatric care. Once inside an adult facility, juveniles are subject to Administrative Segregation because the MDOC classification system does not consider age as a factor in inmate classification.

C. Transferring Out of Administrative Segregation Through the “Incentives In Segregation Program”

Once transferred or reclassified to Administrative Segregation, the prisoner’s immediate thought is how to be released or transferred out of the unit. MDOC Policy Directive 04.05.120 lists four factors to be considered when deciding whether a prisoner should be released or reclassified. However, this policy has not been updated since 2010; and beginning in 2014, the MDOC implemented a new program titled the “Incentives in Segregation Program.” The program resulted from external pressure to prove its segregation standards and policies were adequate to ensure prisoner safety. The goal behind the program was to reduce the overall length of segregation for prisoners while maintaining safe management of the general population. Michigan’s Director of Corrections, Daniel Heyns, stated “[t]he program employs a six stage progression of behavior expectations and incentives to encourage appropriate conduct by the prisoner.” Furthermore, prisoners participating in the program will have

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51. See infra pp. 331–36.
54. Id.
57. Admin. Segregation Report to the Leg., supra note 29.
59. Id.
“a clear understanding of the conduct . . . expected of them . . . [and the] clearly defined expectations also will assist staff . . . ”

Incentives associated with each stage of the “Incentives in Segregation” program break down into two parts: (1) incentives guaranteed at each stage; and (2) incentives which must be authorized or approved, at each stage, by MDOC before the prisoner is granted the incentive. Essentially, guarantees to incentives are significantly limited to basically three showers and five-hours of recreation time per week. Moreover, a prisoner is not guaranteed release from segregation, even if he satisfactorily completes all six stages, because the SCC and MDOC still retain full responsibility and discretion in approving all releases from segregation. Thus, without guaranteed access to essential privileges—such as telephone calls, extra out of cell time, recreation equipment, literature, or cups—what incentives do prisoners have to progress through the program and back into general population? Moreover, preventing access to books, recreation, and human interaction can prove to be detrimental in one’s transition from Administrative Segregation back into general population, especially for juveniles and prisoners with mental illness.

III. EFFECTS OF ADMINISTRATIVE SEGREGATION

Administrative Segregation is widely recognized as extremely harmful. Indeed, people held in Administrative Segregation often experience negative psychological and physiological reactions such as:

- hypersensitivity to stimuli;
- perceptual distortions and hallucinations;
- increased anxiety and nervousness;
- revenge fantasies, rage, and irrational anger;

60. Id.
62. Id.
63. Id. Prisoners considered high risk must be approved by the warden or a higher authority like the SCC; see also SEGREGATION STANDARDS, supra note 33.
64. See infra notes 65–83.
68. Grassian, supra note 65, at 1453; Holly A. Miller & Glenn R. Young, Prison Segregation: Administrative Detention Remedy or Mental Health Problem, 7 Crim. Behav. & Mental Health 85, 91 (1997); Haney, supra note 66, at 130–34; see generally Hans Toch, MOSAIC OF DESPAIR: HUMAN BREAKDOWN IN PRISON (1992).
• fears of persecution;\textsuperscript{69}
• lack of impulse control;\textsuperscript{70}
• severe and chronic depression;\textsuperscript{71}
• appetite loss and weight loss;\textsuperscript{72}
• heart palpitations;\textsuperscript{73}
• withdrawal;\textsuperscript{74}
• blunting of affect and apathy;\textsuperscript{75}
• talking to oneself;\textsuperscript{76}
• headaches;\textsuperscript{77}
• sleeping problems;\textsuperscript{78}
• confusing thought processes;\textsuperscript{79}
• nightmares;\textsuperscript{80}
• dizziness;\textsuperscript{81}
• self-mutilation;\textsuperscript{82} and
• lower levels of brain function, including a decline in EEG activity after only seven days in segregation.\textsuperscript{83}

Additionally, suicide rates and incidents of self-harm are much higher for prisoners in Administrative Segregation.\textsuperscript{84}

Across the states, and the country, there is a common misconception that the prisoners placed in Administrative Segregation are the most dangerous prisoners.\textsuperscript{85} On the contrary, hundreds of the people in

\textsuperscript{69} Grassian, \textit{supra} note 65, at 1453.
\textsuperscript{70} Id.; Miller & Young, \textit{supra} note 68, at 92.
\textsuperscript{71} Grassian, \textit{supra} note 65, at 1453; Miller & Young, \textit{supra} note 68, at 92; Haney, \textit{supra} note 66, at 131.
\textsuperscript{72} Haney, \textit{supra} note 66, at 133.
\textsuperscript{73} Id.
\textsuperscript{74} Miller & Young, \textit{supra} note 68, at 91.
\textsuperscript{75} Id.
\textsuperscript{76} Haney, \textit{supra} note 66, at 134; see generally Brodsky & Scogin, \textit{supra} note 67.
\textsuperscript{77} Haney, \textit{supra} note 66, at 133.
\textsuperscript{78} Id.
\textsuperscript{79} Id. at 137; see generally Brodsky & Scogin, \textit{supra} note 67.
\textsuperscript{80} Haney, \textit{supra} note 66, at 133.
\textsuperscript{81} Id.
\textsuperscript{84} Written Testimony of the ACLU at 10 (2014) (for a hearing on “The State of Civil and Human Rights in the United States,” authored by Laura Murphy).
\textsuperscript{85} See Alison Shanes et al., \textit{Solitary Confinement: Common Misconceptions & Emerging Safe Alternatives}, VERA INST. OF JUST., May 2015.
Administrative Segregation suffer from severe mental illness or cognitive disabilities.\textsuperscript{86} Moreover, children in both adult and juvenile systems are routinely subjected to Administrative Segregation.\textsuperscript{87} While all prisoners placed into Administrative Segregation suffer detrimental effects,\textsuperscript{88} the scope of this Note is on the mentally ill and juveniles. Therefore, this section will break down the specific threats to which these two classes of prisoners are susceptible. However, due to the unique differences between prisoners with mental illness and juvenile prisoners, the effects on each class of prisoner population will be examined separately.

A. Effects On Mentally Ill Prisoners

To fully understand the detrimental effects segregation has on mentally ill prisoners requires an understanding of how mental illness is defined. Michigan Complied Law (“MCL”) 330.1100d(3) defines mental illness as,

a diagnosable mental, behavioral, or emotional disorder affecting an adult that exists or has existed within the past year for a period of time sufficient to meet diagnostic criteria specified in the most recent Diagnostic and Statistical Manual [ (“DSM”) ] of Mental Disorders published by the American Psychiatric Association [ (“APA”) ] and approved by the department [ of Mental Health ] and that has resulted in functional impairment that substantially interferes with or limits [one] or more major life activities.\textsuperscript{89}

A functional impairment can include interferences with basic living skills; instrumental living skills; or appropriate social, behavioral, cognitive, communicable, or adaptive skills.\textsuperscript{90} Additionally, the MDOC has a special classification for prisoners with “serious mental illness,” which is defined by dementia in conjunction with another diagnosable serious mental illness including substance disorder, a developmental disorder, or a “V” code in the DSM.\textsuperscript{91}

In addition to the general deleterious effects of solitary confinement referenced above, prisoners with pre-existing mental illnesses are at greater risk of suffering more permanent and disabling damage.\textsuperscript{92} Prisoners identified as being at the greatest risk of deepened suffering include those who are developmentally disabled, the emotionally unstable, those who

\textsuperscript{86} Id.
\textsuperscript{87} Id.
\textsuperscript{88} See generally Haney, supra note 66; Grassian, supra note 65; Lanes, supra note 82.
\textsuperscript{89} MICH. COMP. LAWS § 330.1100d(3) (2015) (emphasis added).
\textsuperscript{90} MICH. COMP. LAWS § 330.1100b(5) (2014).
\textsuperscript{91} MICH. COMP. LAWS § 330.1100d(3) (2015).
\textsuperscript{92} Haney, supra note 66, at 142.
suffer from mood disorders or clinical depression, and those who have lost touch with reality. As one psychiatric expert explained:

Prisoners who are prone to depression and have had past depressive episodes will become very depressed in isolated confinement. People who are prone to suicide ideation and attempts will become more suicidal in that setting. People who are prone to disorders of mood... will become that and will have a breakdown in that direction. And people who are psychotic in any way... will have another breakdown. 

This expert’s statement is supported by the descriptions given by most mentally ill prisoners who describe their experience as psychological torture with varying degrees of psychic pain. The following cases will illustrate the serious, and sometimes fatal, consequences these prisoners suffer when they are unable to cope with the daily stresses of their confinement.

First, the death of Ozy Vaughn, a mentally disabled prisoner with a history of schizophrenia, illustrates the quick deterioration prisoners experience when they are unable to adapt to their environment. Mr. Vaughn was placed in solitary on a Friday, as a result of prison officials observing his “strange behavior” which was described as: confusion; difficulty following directions; refusing to eat or drink; and standing naked over his cell mate preaching the bible—all of which can be categorized as normal reactions or behavior from someone suffering from schizophrenia. But Mr. Vaughn would only continue to deteriorate after being placed into isolation. A report on the following Monday of Mr. Vaughn’s weekend behavior, just three days after being placed in solitary, indicated he had, at times, been standing in a position for hours; babbling non-sense; appeared to be in a catatonic state; sweated profusely; and vomited. Unfortunately, he was not transferred out of solitary because his reviewing psychiatrist “didn’t feel that [his] status was life threatening.” As a result, Mr. Vaughn died early Tuesday morning, after just four days in solitary confinement.

93. Id.
97. Id.
98. Id.
99. Id. at 663.
100. Id. at 661.
101. Id.
Second, the death of Timothy Souders is a well-known tragedy from MDOC’s use of confinement on a mentally ill prisoner. Mr. Souders’ case highlights the serious implications, which can result from improper medical care; and the extreme conditions prisoners, especially with mental illness, are subjected to in isolation. Mr. Souders, who was twenty-one years old at the time, had already been diagnosed and struggled with bi-polar disorder and depression, and had a history of suicide attempts throughout his lifetime.

After taking an unauthorized shower on a hot day, Mr. Souders was moved to isolation. On the first day, Mr. Souders was restrained for damaging a metal stool in his isolation cell. Later that same day, while still restrained from the stool incident, Mr. Souders attempted to flood his cell, prompting a supervisory nurse to shut off his water and place him on a concrete slab with metal restraints on his wrists and ankles. This required the observation of a mental health worker who reported observing Mr. Souders as “floridly psychotic” and incoherent, but no emergency intervention by the mental health staff came of this observation.

Mr. Souders’ condition would continue to deteriorate rapidly in his third and fourth days of restrained confinement. Around day three, Mr. Souders was stripped naked and left restrained on the concrete slab, after repeatedly urinating on himself while restrained. As a result, Mr. Souders began to develop pressure ulcers and sores on his skin from being restrained in the same position for several days while lying in his own urine. On the fourth day, Mr. Souders was given his first opportunity to shower since being placed in isolation, but by then he was unable to stand on his own and required a wheelchair. Following his shower, Mr. Souders fell from his bed and could not get back up. A nurse was summoned to his room where she observed a weak pulse indicating emergency care was once again needed. But neither the nurse nor any other prison official ordered the necessary emergency care.

103. Id. at 577–78.
104. Id. at 577.
105. Id.
106. Id.
107. Id. at 578.
108. See Hadix, 461 F. Supp. 2d at 578.
109. Id. at 577.
110. See id.
111. Hadix, 461 F. Supp. 2d at 579.
112. See id.
113. Id.
114. Id. at 579–80.
Souders died an hour after the nurse indicated care was needed and just four days after entering isolation.\textsuperscript{115} The deaths of both Ozy Vaughn and Timothy Souders are just two of the many fatal cases that illustrate how quickly mentally ill prisoners’ already unstable conditions can turn life threatening as a result of isolation.\textsuperscript{116} Additionally, emergency signs and symptoms were evident and acknowledged more than once in both cases.\textsuperscript{117} But, as is too often the case, these signs and symptoms are often overlooked or downplayed. As a result, prison systems failing to realize this fact will end up blaming—and punishing—prisoners for manifesting psychological conditions, which should be treated.\textsuperscript{118}

The above evidence and research leaves good reason to believe that most mentally ill prisoners will suffer significant deterioration and decompensation resulting from the psychic assault of dehumanized isolation, the lack of caring human contact, the profound idleness and inactivity, and the extraordinarily stressful nature of solitary confinement.\textsuperscript{119}

\textbf{B. Effects On Juvenile Prisoners}

The use of solitary confinement has extreme and detrimental psychological, physical, and developmental effects on adults.\textsuperscript{120} These destructive effects are magnified when applied to youth.\textsuperscript{121} As a young juvenile girl said, “I felt] doomed, like I was being banished . . . like you have the plague or that you are the worst thing on earth. Like you are set apart [from] everything else. I guess [I wanted to] feel like I was part of the human race—not like some animal.”\textsuperscript{122} These words not only offer a small insight into the thoughts of a youth in solitary confinement, but also resemble the observations made by Charles Dickens in 1842.\textsuperscript{123} The discussion of juveniles in this section will broadly encompass and discuss

\begin{thebibliography}{99}
\bibitem{115} Id. at 580.
\bibitem{116} See, e.g., Clark-Murphy v. Forebeck, 439 F.3d 280, 282 (6th Cir. 2006); Comstock v. McCrary, 273 F.3d 693, 697 (6th Cir. 2001).
\bibitem{117} See Hadix, 461 F. Supp. 2d at 577–80.
\bibitem{118} See Gibson v. Moskowitz, 523 F.3d 657, 661–62 (6th Cir. 2008) (exhibiting symptoms of schizophrenia); see also Hadix, 461 F. Supp. 2d. at 578 (observing Mr. Souders “[e]xhibit[s] symptoms consistent with his description of manic episodes prior to incarceration.”).
\bibitem{119} See supra text accompanying notes 65–118.
\bibitem{120} See supra pp. 327–31.
\bibitem{121} See infra pp. 331–37.
\bibitem{122} \textsc{Human Rights Watch} \& \textsc{ACLU}, \textsc{Growing Up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States 22} (2012 Human Rights Watch) [hereinafter \textsc{Growing Up Locked Down}] (interview by Human Rights Watch with Molly J. (pseudonym), Michigan (Mar. 2012)) (emphasis added).
\bibitem{123} \textsc{Dickens}, \textit{supra} note 8, at 239.
\end{thebibliography}
juveniles with and without mental illness, and it will be in the context of a juvenile being held at an adult facility.

In Michigan, a juvenile is defined as a “person who is less than [seventeen] years of age who is the subject of a delinquency petition.”\footnote{Mich. Comp. Laws § 712A.1(1)(i) (2015); see also Mich. Comp. Laws § 712A.2 (2015) (delinquency petition).} As mentioned above, a juvenile can end up in an adult facility automatically, by waiver, or by designation.\footnote{Mich. Dep’t of Corr., Policy 05.01.140: Prisoner Placement and Transfer, ¶¶ CC–GG (2015); see MDOC Policy Surrounding Administrative Segregation, supra.} Once inside an adult facility, the juvenile is treated in the same manner as every other prisoner.\footnote{See Growing Up Locked Down, supra note 122, at 64.} However, national research shows youths in adult prisons and jails are twice as likely to be beaten by staff, five times as likely to be sexually assaulted, and thirty-six times more likely to commit suicide than similarly situated youths within the juvenile justice system.\footnote{Michelle Weemhoff & Kristen Staley, Mich. Council on Crime & Delinq., Youth Behind Bars 6 (May 2014).} “Because of these high risks, prisons often place youth in segregation or restraints, unfortunately, this only serves to increase risk of depression, anxiety, and self harm.”\footnote{See id. at 127.} In some cases, if the prison does not transfer the youth, then the youth will request a transfer to segregation or act out with the intention of being moved to safety.\footnote{Id.} Further, reports indicate juveniles, once in solitary, can spend up to a few months in isolation where they have described being allowed one-hour per day, alone, out-of-cell to shower or, if permitted, make phone calls to loved ones.\footnote{See Growing Up Locked Down, supra note 122, at 55 (Michigan juvenile describing his experiences in an adult facility, “They moved me to a pod with adults. These guys were much older. They were nowhere near 17. [I was there] about three weeks. Then I couldn’t take it. Just the thought, every day, asking, ‘What’s going to happen?’... Maybe they are coming for me next. I got paranoid... [they transferred me back to isolation]. It was better. You weren’t as scared because [I knew no one was going to wake up in the middle of the night and harm me.”).}

Virtually every young-person subjected to isolation suffers deleterious effects which can affect youths in many ways ranging from permanent mental impairment to suicide.\footnote{See id. at 127.} The Juvenile Justice Reform Committee has stated:

The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions. Furthermore, the

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126. See Growing Up Locked Down, supra note 122, at 64.
128. Id.
129. See Growing Up Locked Down, supra note 122, at 55 (Michigan juvenile describing his experiences in an adult facility, “They moved me to a pod with adults. These guys were much older. They were nowhere near 17. [I was there] about three weeks. Then I couldn’t take it. Just the thought, every day, asking, ‘What’s going to happen?’... Maybe they are coming for me next. I got paranoid... [they transferred me back to isolation]. It was better. You weren’t as scared because [I knew no one was going to wake up in the middle of the night and harm me.”).
130. See id. at 127.
131. See id.
majority of suicides in juvenile correctional facilities occur when the individual is isolated or in solitary confinement.132

The mental and physical effects of solitary confinement are intensified in the context of youth solitary confinement. As the Supreme Court has recognized, there are differences between adults and children which require special consideration of the mental and physical impact on the latter.133 These differences exist in brain development, mental health, and social, emotional, and educational development.134

The human body undergoes significant changes during adolescence, including development of the brain’s frontal lobe.135 Incomplete development of the frontal lobe, which is responsible for cognitive processing, can result in impulsive and immature decision-making processes.136 This rationality component of the brain, in fact, does not fully develop until around twenty to twenty-five years old.137 Thus, at developing stages, where youths are highly emotional and vulnerable, a negative stimulus or lack of stimulation from the environment can be particularly harmful.138

Behavioral evidence has shown how a lack of stimulation is far more harmful to an individual’s development than physical, sexual, or verbal abuse.139 This evidence is illustrated by a boy who entered prison at fourteen describing how he struggled to get through several punitive isolation sentences:

I felt like I was going mad. Nothing but a wall to stare at. This was my tenth wall to stare at in my detention. I started to see pictures in the little bumps in the walls. Eventually, I said the hell with it and started acting insane. [I] made little characters with my hands and acted out [video] games I used to play on the out[side]—Dragon Ball Z, Sonic,

134. See generally Weemhoff & Staley, supra note 127.
138. Id.
Zelda—stuff like that. The [corrections officers] would stare at me—looking at me like I’m crazy. . . . I started talking to myself and answering myself. Talking gibberish. I even made my own language—[corrections officers] didn’t know what I was talking about.  

The lack of stimulation is not just detrimental while in isolation; it also extends to a youth’s mental ability once back in general population.\textsuperscript{141} In particular, some youths have described diminished reasoning and learning abilities as a result of confinement, while one boy described feeling mentally slower and stated, “[confinement] absolutely slowed down my thinking skills. I would come out of [solitary] and be demonstrably slower. Following conversations, doing math work, my brain slowed down quite a bit.”\textsuperscript{142} 

Prolonged exposure to solitary confinement not only affects brain development but can exacerbate—or even cause—mental disabilities or other serious health problems.\textsuperscript{143} Specifically, youths subjectively perceive time differently and often describe “losing touch with reality while isolated.”\textsuperscript{144} These effects of isolation on the immature brains of the youth are particularly evident when considering the personal descriptions of youths in confinement.\textsuperscript{145} One young girl in Michigan recalled, “there was no window at all . . . I couldn’t see a clock . . . the only way I associated any kind of time—I broke down time: morning, afternoon, evening. I broke it down: breakfast, lunch, and dinner . . .”\textsuperscript{146} 

At other times, despite their best efforts, youths felt like they faced a losing battle with themselves and reality. One young man described putting covers over his head in an attempt to “try [and] disassociate” himself but found it “impossible for any person to cope with anything like [solitary confinement].”\textsuperscript{147} Another boy described feeling stressed, having anxiety attacks, and claustrophobia to the point where he was “literally going insane in that little spot.”\textsuperscript{148} 

A youth’s ability to control and understand their emotions is also negatively impacted by solitary confinement because this ability does not start to develop until later into adulthood.\textsuperscript{149} This mental instability makes youths susceptible to fits of anger, rage, nervousness, and paranoia; but the

\footnotesize{\textsuperscript{140} Growing Up Locked Down, supra note 122, at 25.  
\textsuperscript{141} See infra pp. 334–36.  
\textsuperscript{142} Id. at 44.  
\textsuperscript{143} Id. at 24.  
\textsuperscript{144} Id. at 1–15.  
\textsuperscript{145} See infra pp. 335–37.  
\textsuperscript{146} Id. at 22.  
\textsuperscript{147} Growing Up Locked Down, supra note 122, at 26.  
\textsuperscript{148} Id.  
\textsuperscript{149} The Solitary Confinement of Youth in New York, supra note 118, at 31 (Dec. 2014) (citing Bandy Lee, briefing testimony at 184).}
extent of cognitive and psychological devastation is not immediately known because some serious mental disabilities do not manifest until late adolescence.\textsuperscript{150} One woman, after visiting her grandson while he was in solitary, noted “[h]is mind is going and coming when he is locked up by himself all the time… He is jumpy. He is startled when you talk to him… He can’t be still—like a nervous person!”\textsuperscript{151}

On the other hand, some youths experience uncontrollable anger or rage. After being released from isolation, one youth stated, “[a]ll I would want to do is fight.”\textsuperscript{152} Another stated, “I couldn’t sleep. I was having anger. My anger was crazy. I was having outbursts.”\textsuperscript{153} A third recalled, “It makes you worse. It really brings the beast out of you to be in there stressing. You start saying, ‘Fuck everything’… [It] makes you more wild; makes you feel like a lion in a cage.”\textsuperscript{154} The detrimental mental impact solitary confinement places upon youth is often far too much for them to cope with, as shown above.

Moreover, this already detrimental mental impact suffered by youths in solitary is exacerbated if the youth has a previous traumatic experience.\textsuperscript{155} The evidence becomes particularly more alarming because research conducted between 1985 and 2004 found the youth population in Michigan experienced high rates of violence and traumatic experiences.\textsuperscript{156} Experts have found the isolation can trigger previous traumatic experiences, and “leaves [youth] with a potential for a post-traumatic reaction.”\textsuperscript{157}

The detrimental effects of solitary confinement on youth are not limited to mental effects but also extend to physical effects. Research has shown jails and prisons are rarely equipped to appropriately manage or provide for those who are physically immature.\textsuperscript{158} Moreover, research conducted by the ACLU found the confinement of youths, in adult facilities, resulted in a deprivation of exercise and adequate nutrition.\textsuperscript{159} As a result, youths in solitary have reported weight loss,\textsuperscript{160} stunted growth,\textsuperscript{161}

\begin{flushright}
\begin{itemize}
  \item 150. \textit{Growing Up Locked Down}, supra note 122, at 33.
  \item 151. \textit{Id.} at 27.
  \item 152. \textit{Id.}
  \item 153. \textit{Id.}
  \item 154. \textit{Id.}
  \item 155. \textit{See generally} \textit{Weemhoff & Staley}, supra note 127.
  \item 156. \textit{Weemhoff & Staley}, supra note 127, at 9 (more recent studies have not been conducted and/or released by the state).
  \item 157. \textit{Growing Up Locked Down}, supra note 122, at 34–35.
  \item 158. \textit{Growing Up Locked Down}, supra note 122, at 37.
  \item 159. \textit{Id.} at 37.
  \item 160. \textit{Id.} at 37–39.
  \item 161. \textit{Id.} at 39.
\end{itemize}
\end{flushright}
and hair loss.\textsuperscript{162} One girl in a MDOC facility reported going several months, while in and after release from solitary, without menstruating.\textsuperscript{163}

The detrimental effect isolation has on the development of youths extends beyond the confines of cognitive, mental, and physical defects. Youths placed in solitary confinement are also robbed of imperative resources during critical stages of their social, emotional, and educational development.\textsuperscript{164} Additionally, social interaction and human contact have been identified as important for their social development.\textsuperscript{165} But in solitary, youths rarely have social interactions; they are in a cell alone and any time outside of the cell is also alone or under the protection of the guards. Moreover, youths held in solitary in MDOC facilities cannot have human contact with family members when they visit, and are required to sit with a glass window barrier between them.\textsuperscript{166} One youth described the source of his pain and suffering came from the denial of hugs and kisses: “It was very depressing not to be able to give them a hug. I would cry about that.”\textsuperscript{167}

Additionally, youths’ access to educational development is inadequate, if it even exists.\textsuperscript{168} At times, packets with problems are slid under the door for the youths to complete, but no one checks the problems or answers their questions.\textsuperscript{169} Of course, an unchecked packet is better than the flat out denial of educational services once the confinement door has closed, as has been reported to happen.\textsuperscript{170}

As a result, solitary confinement has been found to harm a youth’s “emotional, mental and psychiatric, educational, social, physical health and well-being through the isolation and the forced idleness.”\textsuperscript{171}

IV. RECONSIDERING ADMINISTRATIVE SEGREGATION: TIME FOR CHANGE

Given the detrimental effects juveniles and prisoners with mental illness are subjected to in Administrative Segregation, it makes one wonder why there has not been reform in Michigan. Michigan did revamp its procedures for segregation by adding the “Incentives in Segregation

\begin{itemize}
\item 162. \textit{Id.}
\item 163. \textit{Growing Up Locked Down, supra note 122, at 40–41 (studies have stated this to be the result of stress and trauma).}
\item 164. \textit{Id. at 18–19 (studies show this can be one of the main reasons recidivism is so high because youths returning to the streets and society do not know how to adjust and cope after being subjected to isolation during their sentence).}
\item 165. \textit{See Haney, supra note 66; see also Grassian, supra note 65.}
\item 166. \textit{Growing Up Locked Down, supra note 122, at 19.}
\item 167. \textit{Id. at 42.}
\item 168. \textit{See Growing Up Locked Down, supra note 122.}
\item 169. \textit{Id. at 42–43.}
\item 170. \textit{Id. at 42–43.}
\item 171. \textit{The Solitary Confinement of Youth in New York, supra note 139, at 37.}
\end{itemize}
but nonetheless, prisoners with mental disorders and juveniles are still subjected to Administrative Segregation. Moreover, Michigan’s reform seems non-existent compared to that which other states have implemented. To date, almost half of the states have either reformed their segregation policies to limit or eliminate its use on juvenile and mentally ill prisoners. Additionally, reforms to solitary practices have been initiated by the federal government, as well as by countries around the world.

Reform to states’ Administrative Segregation policies and practices can be broken into three categories: (1) reforms which have been achieved via Legislation; (2) reforms which resulted from a settlement of a lawsuit; and (3) states which have announced plans to reform.
This section will examine two states with the most effective and extensive reform: New York and Colorado. Specifically, this section will discuss why these two states began their reform, the outcomes of the reform, and demonstrate two of the ways to initiate reform. In particular, how one of the ways allows the state, and its Department of Corrections (“DOC”), to control reform efforts, while the other way dictates how the State, and its DOC, must conduct their reform.

A. New York Reform—A Three-Stage Process

Administrative Segregation practices in New York have seen three reforms since 2007—two from settlements and one from legislative enactment. New York is an example of how the State and its DOC can lose control of reform efforts when the reform comes as a result of a settlement agreement. While reform resulting from a settlement is not necessarily a bad thing, it limits the State’s ability to reform practices in a way it finds appropriate.

1. 2007 Settlement Reform (Stage 1)—Disability Advocates v. New York State Office of Mental Health

Reform to New York Department of Corrections practices surrounding solitary confinement began in 2007 as part of a settlement in Disability Advocates v. New York State Office of Mental Health (“DAI v.
The lawsuit, which began in 2002, alleged that prisoners throughout the New York State prison system were not provided the treatment they needed. As a result, many prisoners in need of mental health services often were punished with 23-hour lockdown, during which many suffered severe psychiatric deterioration. The settlement required prisoners with serious mental illness held in solitary confinement to receive a minimum of two hours of out-of-cell. Additionally, the settlement provided:

- multiple reviews of disciplinary sentences for the purpose of removing prisoners with serious mental illness from isolated confinement;
- residential and intermediate care programs for more than 500 prisoners with mental illness;
- improved treatment and conditions for prisoners in psychiatric crisis in observation cells; and
- elimination of isolated confinement of prisoners with serious mental illness in cells that have solid steel doors severely isolating and restricting communication.

2. 2008 Legislative Reform (Stage 2)—SHU Exclusion Law

In 2008, the Special Housing Units Exclusion Law, better known as the SHU Exclusion Law, was enacted to ensure inmates with serious mental illness would not languish in segregated confinement, but would be transferred and placed into a Resident Mental Health Treatment Unit ("RMHTU"). The law expanded on the reforms mandated by mental health advocates in the DAI v. OMI settlement agreement. However, the Law did not take effect until 2011 because of the vast amount of reform required by the SHU Exclusion Law and DAI settlement.

182. Id. at *1.
183. Id.
186. Some states call these units “Segregated Housing Units” but both have the same purpose or meaning.
188. Id.
189. Id.
At the core of the SHU Exclusion Law is a requirement to divert prisoners with serious mental illness to a RMHTU, if they “could potentially” be in SHU for a period in excess of thirty days. The SHU Exclusion Law defines RMHTU as:

[H]ousing for inmates with serious mental illness that is operated jointly by the department and the office of mental health and is therapeutic in nature. Such units shall not be operated as disciplinary housing units, and decisions about treatment and conditions of confinement shall be made based upon a clinical assessment of the therapeutic needs of the inmate and maintenance of adequate safety and security on the unit. Such units shall include, but not be limited to, the residential mental health unit model, the behavioral health unit model, the intermediate care program and the intensive intermediate care program.

Thus, the Law restricts punishments from being imposed on prisoners housed in the RMHTUs. Amongst these restrictions are:

- no restricted diet penalties may be imposed;
- no misbehavior reports for refusing treatment or medication are allowed; and
- misconduct in the RMHTU shall not “be sanctioned with segregated confinement for misconduct on the unit, or removed from the unit and placed in segregated confinement, except in exceptional circumstances.”

Moreover, there are further restrictions on who may, in extraordinary circumstances, remove an inmate from an RMHTU to segregated confinement in a SHU.

In sum, the SHU Exclusion Law expanded on the DAI v. OMI settlement and ensures prisoners with mental illness are afforded proper treatment by placing them in RMHTUs designed to treat mental health issues rather than create them.

3. 2014 Settlement Reform (Stage 3)—Peoples v. Fischer

New York’s most notable reform came in the wake of a 2014 settlement with the New York Civil Liberties Union (“NYCLU”) in Peoples v. Fischer. The plaintiff, Leroy Peoples, spent 780 days locked in a tiny, barren cell the size of an elevator for twenty-three hours a day as

190. Id.
191. N.Y. CORRECT. LAW § 2.21 (McKinney 2014); See Implementation of Special Housing Units (SHU) Exclusion Law, supra note 187.
192. N.Y. CORRECT. LAW § 401.2(b).
193. Id. at § 401.3.
194. Id. at 401.5(a).
195. Id.
punishment for misbehavior involving no violence or threat to the safety or security of others.\textsuperscript{198} Originally, the lawsuit challenged New York’s official policy of “double-celling,”\textsuperscript{199} but was later amended to extend the scope of the lawsuit to include all individuals incarcerated in state prisons similarly affected by the policies and practices permitting the arbitrary and unnecessary use of solitary confinement.\textsuperscript{200}

An interim agreement between NYCLU and the New York Department of Corrections, resulting from the Peoples litigation, was announced in 2014.\textsuperscript{201} New York, while reforming the way solitary confinement was used in the State’s prisons, was required to take immediate steps to remove youth, developmentally disabled and intellectually challenged prisoners, and pregnant inmates from extreme isolation.\textsuperscript{202} Two experts created a series of recommendations for how New York should reform its use of isolated confinement.\textsuperscript{203} But, the recommendations would take nearly two years to be implemented, analyzed and memorialized in a final settlement agreement between the two parties.\textsuperscript{204}

Under the final settlement announced in December of 2015, New York committed itself to (1) reducing solitary, (2) limiting the length of solitary sentences, and (3) increasing rehabilitative features in solitary and abolishing its most dehumanizing aspects.\textsuperscript{205} New York has until the end of 2018 to implement the agreement, followed by a two-year monitoring period.\textsuperscript{206} The following are major provisions which New York is required to comply with by 2018:\textsuperscript{207}

- Remove more than 1,100 people from traditional solitary confinement and either move them to rehabilitative units or less isolating disciplinary units. The removal focuses on prisoners with developmental disabilities, juveniles, prisoners in need of drug therapy or more comprehensive behavioral therapy, and prisoners who would otherwise be released directly from solitary to the street;

\textsuperscript{198} Id.; Sec. Am. Compl. ¶¶ 1, 68, 74.
\textsuperscript{199} Id. (“double-celling” is the practice of placing two prisoners inside a single isolation cell); Sec. Am. Compl. ¶¶ 88, 89.
\textsuperscript{202} Id.
\textsuperscript{203} Id.
\textsuperscript{204} Id.
\textsuperscript{205} Id.
\textsuperscript{206} Historic Settlement Overhauls Solitary Confinement in New York, supra note 201.
\textsuperscript{207} Id.
• Restrict the circumstances in which solitary may be imposed as punishment; 208
• Require de-escalation training for all 20,000 NYDOC personnel, on how to diffuse situations before solitary becomes a consideration;
• Impose a maximum sentence of three months for solitary confinement for all but a handful of first-time violations, and a maximum of thirty days for almost all non-violent first-time violations;
• Provide basic human needs for people in solitary such as: telephone calls, reading materials, shower curtains (in shared cells), and abolish the use of serving inedible food as a form of starvation punishment;
• Establish a robust monitoring regime to ensure compliance with the terms of the settlement, including quarterly reporting to the public. 209

As a result of these changes, New York is the largest state prison system in the United States to eliminate the use of solitary confinement as a disciplinary measure against juvenile prisoners under the age of 18. 210 Additionally, the reform is focused on reducing NYDOC’s reliance on segregation by limiting, and reserving, segregation for only the most violent offenders. 211 But even then, the reform ensures prisoners who are placed in segregation are guaranteed release after a maximum time and are provided with basic human needs. 212

While New York’s reform is a benchmark for many states, including Michigan, to reference or duplicate in their own states, it also provides a lesson to be learned—if the state does not voluntarily initiate reform, then the reform may be in the hands of the court and not the state.

B. Colorado Reform

Colorado, unlike New York, voluntarily elected to change their Administrative Segregation practices via legislative reform and recommendations from a self-initiated external review of the Colorado Department of Corrections (“CDOC”). 213 The State’s first Administrative

208. Sixty-five of the eighty-seven rule violations formerly punishable by solitary have either reduced eligibility for solitary or eliminated the possibility altogether. Id.
209. Michigan Department of Corrections does not require public reporting.
211. See id.
212. See id.
Segregation facility was established in 1993 and implemented the traditional twenty-three hour a day segregation standards. By 2011, Colorado had one of the highest Administrative Segregation populations in the country. Thus prompting then Executive Director of Colorado Department of Corrections, Tom Clements, to start advocating for a restructuring of Colorado’s Administrative Segregation program. Clements, in 2011, requested the National Institute of Corrections ("NIC") to head an external review of CDOC’s Administrative Segregation policies. At the same time, the Colorado Legislature laid a foundation for Administrative Segregation overhaul in the form of Senate Bill 11-176. The NIC Review and SB 11-176 helped project the State into reforming the Administrative Segregation program in Colorado prisons.

1. NIC REPORT

   In 2011, philosophies regarding Administrative Segregation practices began to shift; and Tom Clements felt that change was necessary in Colorado. Clements requested the NIC to assist in the Reform process. The NIC is an agency inside the Department of Justice which “provide[s] training, technical assistance, information services, and policy/program development assistance to federal, state, and local corrections agencies.” Additionally, the NIC provides “leadership to influence correctional policies, practices, and operations nationwide in areas of emerging interest and concern to correctional executives and practitioners as well as public policymakers.” Thus, the NIC sends its members to corrections facilities to help identify issues in the facilities’ policies, and recommends more appropriate and effective measures to the facilities’ practices.

   After three days on site at Correctional Facilities, two members of the NIC, heading the external review, reported their major findings and

214. Id.
215. Id.
216. Id.
217. Id.
219. Open the Door—Segregation Reforms in Colorado, supra note 213.
220. Id.
221. Id.
223. Id.
224. Id.
recommendations. The following five examples come from the eighteen major findings the NIC reported in relation to CDOC’s segregation program. First, the NIC found prison population to be slightly declining, but Administrative Segregation population increasing, as well as the proportion listed as having a significant mental health condition. Second, it discovered considerable confusion surrounding the operational memoranda and regulations on how the Administrative Segregation units are to function. Third, the average length of stay in segregation was about two-years, with a median length of stay of fourteen months. Fourth, about forty-percent of the offenders were released from Administrative Segregation directly into the community. Finally, the decision to refer an offender to Administrative Segregation was largely controlled at the various facilities limited oversight by Central Office.

As a result of these major findings, the NIC made twelve Administrative Segregation recommendations. Among the recommendations were: (1) mental health review before any placement into Administrative Segregation, and monthly out-of-cell review thereafter; (2) thirty minutes out-of-cell contact with a case manager each month; (3) a four-level “step-down” process with specific rules and privileges associated with each phase; and (4) narrowly tailored criteria for which a person can be admitted to Administrative Segregation.

2. SB 11-176

As mentioned, while the NIC was reviewing CDOC’s segregation policies, the state legislature was crafting SB 11-176. The bill, which was enacted in 2011, directly addressed the use of restrictive housing in Colorado, and the mental health of prisoners – particularly those with mental illnesses. Moreover, it focused on requiring mental health checks before prisoners are placed into segregation; and also established a maximum time limit that prisoners may be held in Administrative

226. Id. at 17–18.
227. Id. at 17.
228. Id.
229. Id. at 18.
230. Id.
231. Austin & Sparkman, supra note 225, at 17.
232. Id. at 18–19.
233. Id.
235. S. 11–176, 1st Sess. at § 1, 17-1-113.9(1) (Colo. 2011).
To ensure the focus is continued to be met, SB 11-176 has two mandatory requirements. First, the Executive Director of the DOC, on or before the first day of each year, must:

- provide a written report to the judiciary committees of the Senate and House of representatives, or any successor committees, concerning the status of administrative segregation; reclassification efforts for offenders with mental illnesses or developmental disabilities, including duration of stay, reason for placement, and number and percentage discharged; and any internal reform efforts since July 1, 2011.

The purpose of the report is to describe ongoing efforts to review and modify the use of long-term solitary confinement within the CDOC, while making the information public for anyone to follow. Second, SB 11-176 requested cost savings to be redirected into mental health services and other programs. This requirement ensures all savings from reducing the Administrative Segregation population is put towards the focus of the reform—mental health—and not used elsewhere in the CDOC or State.

3. **Colorado Reform Resulting from NIC Report and SB 11-176**

With the passage of SB 11-176 and the recommendations from the NIC Review, Colorado has seen its segregation population drop to one of the lowest in the country. The enacted bill and NIC Report compelled the CDOC to create and implement various reform programs and step-down units which have aided in the rapid reduction of segregation population since 2011. The reform efforts focused upon the use of restrictive housing for only the most violent, dangerous and disruptive offenders, while excluding offenders with serious mental illness from being considered for Administrative Segregation housing placement. This was accomplished by creating three alternative programs, or step-down units; and re-naming Administrative Segregation to “restrictive housing units.”

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236. Id.; see also S. 11-176, 1st Sess. at § 4, 17-22.5-405 (Colo. 2011).
237. Id. at § 1, 17-1-1139(1).
239. S. 11-176, 1st Sess. at § 1, 17-1-1139(2) (Colo. 2011).
240. See supra note 238.
243. Id. at 2–3. In 2015, CDOC added juveniles to the list of being excluded from Administrative Segregation placement.
244. Id. at 3–7.
First, CDOC abolished all previous terms and levels associated with Administrative Segregation, and replaced them with a new restrictive housing policy—maximum security status. Second, to prevent prisoners from being directly released to the community from Administrative Segregation, CDOC developed two programs/units to ensure a successful transition from restrictive housing to general population: (1) Close Custody Management Control Unit (MCU); and (2) Close Custody Transition Units (CCTU).

The MCU is the first progression from restrictive housing and offers prisoners increased time out-of-cell, pro-social group activities, and mental health and case management assessment every thirty days. The CCTUs, on the other hand, serve as a progression for prisoners from the MCU and offers additional time out-of-cell with more prisoners, including recreational activities. Both the MCUs and CCTUs were established as step-down units “designed specifically to assist offenders with pro-social stabilization and cognitive intervention programming prior to progression to larger general population living environments.”

Lastly, Residential Treatment Programs were created to provide extra care and support for offenders with serious mental illness or intellectual disability. This program ensured these individuals are not placed in Restrictive Housing Settings. The goal of the program is to maintain pro-social interactions which is accomplished by removing prisoners with serious mental illness from the disciplinary process when an infraction is committed. In other words, rather than punishing these prisoners for infractions which are committed due to their mental illness, problematic behaviors are now addressed through treatment modifications.

V. A SAFER, MORE-EFFECTIVE APPROACH TO ADMINISTRATIVE SEGREGATION FOR ALL PRISONERS—ESPECIALLY PRISONERS WITH MENTAL ILLNESS AND JUVENILES

Michigan’s current concept of Administrative Segregation runs contrary to the stated goals of the Michigan Department of Corrections—holding offenders accountable and promoting their rehabilitation. There

245. Id. at 3.
246. Id. at 4–5.
247. Id. at 4.
249. Id. at 3.
250. Id. at 2.
251. Id. at 5.
252. Id.
253. See Open the Door—Segregation Reforms in Colorado, supra note 213.
254. MICH. DEP’T OF CORR., POLICY 01.01.100—MISSION STATEMENT (2011) (emphasis added).
are more effective ways to meet MDOC’s mission, as over half of the states have already demonstrated.\textsuperscript{255} One of those ways is by forbidding the use of Administrative Segregation for prisoners with mental illness, intellectual disabilities, and those under the age of 21. This section will be broken into two types of reform: (1) reform to the segregation unit for the benefit of prisoners with mental illness; and (2) reform specific to juveniles. The first type will explain and layout a reform to the segregation units, as well as introduce specific programs which MDOC should implement. The second reform will discuss current Michigan Legislation, called the “Youth in Prison Package,” which is aimed at protecting Juveniles. Lastly, this Note will discuss how MDOC officials are crucial to the success of the reform; set a projected time line for how long this reform would take to implement; and introduce how the reform can be afforded by MDOC and the State.

A. Reforming Michigan’s Segregation Units to Protect Prisoners with Mental Illness

Administrative Segregation is currently used to “achieve effective administrative management, maximum disciplinary control, and individual prisoner protection.”\textsuperscript{256} However, the current policy is not suitable to achieve these results. In order for MDOC to properly achieve these goals a new structure must be created to: (1) ensure Administrative Segregation is only used for the most violent offenders; (2) provide safer transition units for prisoners returning to the general population or the community; and (3) promote rehabilitation with an updated incentives program designed to prevent prisoner placement in Administrative Segregation.

This Note proposes implementing an Administrative Segregation program structured similar to the ones in New York\textsuperscript{257} and Colorado\textsuperscript{258} The program would have two segregation units: (1) an Administrative Segregation unit; and (2) a Close Custody Transition Unit; and would create a Residential Treatment Program designed specifically for prisoners with mental illness. Under the new program, the Administrative Segregation unit would remain but prisoners with mental illness or those below the age of 21 would be prohibited from placement there—reserving Administrative Segregation only for the most violent and dangerous offenders. The CCTU would act as a transition unit for prisoners transferring from Administrative Segregation back to the general population, or for prisoners exhibiting behavior which warrants cognitive programming.

Both the Administrative Segregation unit and CCTU would be monitored closely, but the CCTU would be far less restrictive than

\begin{footnotesize}
\begin{itemize}
  \item[255.] See supra VI – Reconsidering Administrative Segregation: Time for Change.
  \item[256.] SEGREGATION STANDARDS, supra note 33, at ¶ D.
  \item[257.] Supra, New York Reform.
  \item[258.] Supra, Colorado Reform.
\end{itemize}
\end{footnotesize}
Administrative Segregation. The CCTU would focus on reducing recidivism, while also promoting a pro-social environment that would help prisoners step-down and transition back into general population from Administrative Segregation. Specifically, the CCTU is for prisoners who have committed an infraction but their behavior warrants cognitive programming and monitoring. Additionally, prisoners with mental disorders could be placed in the CCTU if they commit an infraction, and it is determined that the mental illness did not cause the behavior. In other words, CCTUs are an added measure to guarantee Administrative Segregation is used only for the most violent and threatening individuals.

Figure one generally illustrates how prisoners can be placed in the different units. Each unit will be discussed individually after the chart. Additionally, the chart also shows how Residential Treatment Programs, a unit designed specifically for prisoners with mental illness, would function in the new system. The scenario begins with a prisoner in general population who just committed an infraction and asks whether the infraction was committed by a prisoner with mental illness. If so, the prisoner is not subject to Administrative Segregation.

![Figure 1](image)

259. If it is determined that the mental illness caused the behavior, then the prisoner would be transferred to a residential treatment program.
As you can see, infractions committed by prisoners with mental illness would only be punishable by transfer into a CCTU or Residential Treatment Program. Whereas, prisoners who commit an infraction, and do not suffer from mental illness, would be subject to Administrative Segregation or a CCTU. The following briefly explains how each unit functions.

1. **Administrative Segregation Unit**

Reform to this unit is focused on ensuring the offenses which result in segregation are designed to capture the most violent, dangerous offenders. The offenses subject to segregation should only include the most dangerous and violent offenses—murder, manslaughter, kidnapping, assault, rape, arson, escape, engaging in or enticing a riot. Additionally, because of the detrimental effects prisoners experience in isolation, MDOC should prohibit prisoners with mental disorders, intellectual disabilities, or those under 21 years old from placement into Administrative Segregation Units. Therefore, the potential for prisoners to be placed in Administrative Segregation and suffer irreparable harm is significantly reduced—by limiting the offenses and prohibiting the placement of prisoners with mental illness and juveniles.

But changes must also be made to promote the rehabilitation of prisoners who are placed into segregation. The following changes in Administrative Segregation will help reduce recidivism, protect against harmful effects of isolation, and provide a safer and more effective environment for both the prisoner and MDOC. Under the reform, prisoners in Administrative Segregation will:

- Receive a maximum three-month sanction in segregation;
- Be guaranteed basic human needs in the Incentives in Segregation Program;
- Extend out-of-cell time to three hours per day, seven days a week; and
- Receive weekly contact visits and reviews by a case manager and mental health clinician.

These changes should be implemented to better protect prisoners against the detrimental effects segregation causes. By providing prisoners in Administrative Segregation with more time out-of-cell and better access to essential materials, prisoners may feel less like caged, helpless animals and more like human beings seeking rehabilitation for their behavior.

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261. See supra Section III.
262. Such as telephone calls, recreational equipment, literature, etc.
263. Reviews will track progression based on behavior and interactions with staff, and will provide the opportunity for prisoners to be released from Administrative Segregation earlier than their sanctioned time.
2. **Close Custody Transition Units**

The CCTU is a transition unit designed to be a less restrictive, more effective placement for prisoners who do not meet the new, stricter requirements for Administrative Segregation. MDOC should implement CCTUs because they will assist in progressing prisoners from Administrative Segregation back to general population. This progression assists prisoners in adapting back into the general population by slowly introducing pro-social environments, prisoner contact, and cognitive behavioral programming. Although the CCTUs are more restrictive than the general population, they are far less restrictive than Administrative Segregation housing and even offers group contact for prisoners placed here.

CCTUs provide inmates the opportunity to receive cognitive behavioral programming and increased offender interaction to prepare them for placement in a less controlled, general population environment. Assignment to a CCTU would be a four-month sentence for prisoners who are progressing from Administrative Segregation, or exhibiting behavior warranting cognitive monitoring. Prisoners in CCTUs will be allowed:

- out-of-cell for a minimum eight (8) hours per day, seven (7) days a week;
- contact with up to sixteen (16) other prisoners;
- participation in out-of-cell activities including recreational, pro-social group hall, and behavioral programming activities; and
- minimum of five (5) hours of indoor or outdoor recreation per week.

The unique feature in CCTUs is that prisoners participate in cognitive behavioral programming sessions which would be designed to aid in the transition to general population by increasing focus on positive social-interactions and development of problem-solving skills. Therefore, CCTUs focus on reducing recidivism, and benefit prisoners by slowly working the prisoner back into general population through progressive units designed to address the side-effects associated with Administrative Segregation and/or cognitive functioning.

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264. Find Me A Cure, *Cognitive Behavioural Therapy* (CBT), http://findmeacure.com/2015/04/10/cognitive-behavioural-therapy-cbt/. Cognitive Behavioral Therapy is designed to change unhelpful behavior and thinking. The technique acknowledges their behaviors may not be controlled through rational thought, but rather emerge based on prior conditioning from the environment and other external/internal stimuli. The therapist seeks to assist the client in selecting specific strategies to help these problems. *Id.*


266. *See supra* text accompanying notes 246–249.
3. Residential Treatment Programs

This Residential Treatment Program (“RTP”) is specifically designed to combat behavior and symptoms caused by mental illness with treatment modification, and is an alternative to placing prisoners with mental illness into more controlled units. The RTP would not excuse a prisoner with mental illness or juvenile from being disciplined for an infraction they committed, or crime they were convicted of; instead these programs are designed to discipline in a way that is more effective to treat their behavioral, mental, and physical needs. The goal of the RTP is to prevent these prisoners from being placed into segregated units where their mental illness can be exacerbated. Therefore, the RTPs provide prisoners with treatment modification to directly assess their needs, rather than punishing uncontrollable behavior or actions with segregation.

Once MDOC determines a prisoner committed an infraction due to their mental illness, then the prisoner is placed in a RTP. This program will provide prisoners with:

- Group therapy and individual sessions with mental health clinicians;
- Weekly review by a case manager to assess treatment needs and overall progression; and
- Minimum twenty-hours out-of-cell per week
  - Ten hours for structured therapeutic interventions, and
  - Ten hours of non-structured recreational opportunities.

Additionally, prisoners who engage in treatment and progress with good behavior will receive incentives such as:

- Allowing dogs to attend treatment groups or meetings with the prisoner;
- Use of de-escalation rooms where the prisoner can listen to soothing music and change his environment; and
- Participate in art therapy where they can draw and express their thoughts without talking.

These incentives promote safety in the environment, and provide prisoners more effective measures to cope with the situation and environment they are in. Moreover, they recognize that some prisoners need to relax by expressing themselves, rather than being punished for their expressions. Thus, once implemented, these programs will allow MDOC to meet its stated goals—holding offenders accountable and promoting their rehabilitation.

267. See Implementation of Special Housing Units (SHU) Exclusion Law, supra note 187.
268. Id.
B. Juvenile Reform—Youth in Prison Package HB 4947-4966

In the Spring of 2016, a package of Bills was introduced in the Michigan Legislature that, if passed, would have sweeping effects on juveniles in the criminal justice system. The “Youth in Prison” package is being called the “largest criminal justice reform package in U.S. history” by its backers. As of December 2016, the Bills have passed the House and now sit in the Senate. This section will give a brief overview, in no particular order, of what each bill addresses and discusses the immediate impact they would have if passed.

HB 4947 through 4954

These bills all surround raising the age regarding juveniles. The bills would amend various statutes to provide for a 17-year-old to be considered a juvenile, rather than treated as an adult in the criminal justice system. These bills would look to raise juvenile jurisdiction to 18 years old, bringing Michigan in line with a majority of the states—currently Michigan is one of nine states in which 17-year-olds are automatically tried as adults.

HB 4966—Solitary Confinement – Time spent in cells for those under 21-years-old

This bill is targeted to ensure a prisoner under 21 years of age is offered certain out-of-cell programming and outdoor exercise. Specifically, the MDOC would have to develop policies to ensure an inmate, including one in Administrative Segregation, who is under 21 is offered age-appropriate out-of-cell programming and outdoor exercise at least five days a week. It would also ensure the prisoner is released from his or her cell every day. However, the bill would still allow for prisoners under the age of 21 to be placed into Administrative Segregation —unlike the reform proposed in this Note.

HB 4965—Family Advisory Board

This bill would create a family advisory board within the MDOC. The board would consist of members who: currently have family in prison;

270. See id.
271. Id.
272. Id.
273. HB 4966, Summary of House-Passed Bill.
274. Id.
275. Id.
276. Id.
277. HB 4965, Summary of House-Passed Bill.
formerly had family in prison; were in prison themselves; social workers; and members from the State Bar of Michigan.\textsuperscript{278} The family advisory board would assist and advise the MDOC regarding the development of policies, procedures, and programs that supported family reunification during and after incarceration.\textsuperscript{279} Precisely, this bill is targeted at preventing recidivism and rehabilitating the juvenile by keeping the family actively involved in the juvenile’s life—even while locked-up.\textsuperscript{280}

HB 4957 through 4959—Prohibits Placement in adult facility

This group of bills is designed to prohibit a child under 18 years of age from being held in a jail or detention facility for adults, but allow him or her to be held in a detention facility for juveniles.\textsuperscript{281} Together, these bills would prohibit adult imprisonment for juvenile offenders, and also prohibit the housing of juveniles with adults.\textsuperscript{282}

Altogether, the Youth in Prison package contains twenty bills: eight surrounding raising the age of jurisdiction regarding juveniles; three concerned with prohibiting juvenile placement in adult facilities; three targeted at eliminating certain offenses from specified juvenile offenses; two on equal consideration of mitigating factors for traditional waiver; and the final four address public monitoring, family advisory boards, solitary confinement, and the County Child Care Fund reimbursement.\textsuperscript{283}

The changes proposed in the package, if passed, would have an immediate impact on juveniles in the criminal justice system. Moreover, many of the proposed changes indirectly go to the heart of this Note. Raising the juvenile age to 18 and prohibiting juvenile placement in adult facilities would eliminate many of the emotional and psychological problems that juveniles face when entering the adult system. In addition, by preventing juveniles from entering adult facilities, it eliminates the possibility that juveniles are placed into Administrative Segregation.

C. Additional Recommendations for the Reform

Prohibiting prisoners with mental illness and youths under twenty-one from placement in Administrative Segregation, creating transition units to limit reliance on Administrative Segregation, and implementing RTPs are all suggested reforms the MDOC should immediately adopt and look to implement. But these suggestions are just the tip of the iceberg and require

\textsuperscript{278} Id.
\textsuperscript{279} Id.
\textsuperscript{280} Id.
\textsuperscript{281} Lawler, supra note 269.
\textsuperscript{282} HB 4957–4959, Summary of House-Passed Bill.
other policy changes in order to truly be effective upon implementation. The author of this Note makes a few general suggestions which MDOC ought to consider implementing if it decides to reform other segregation practices:

- Require all MDOC employees to undergo de-escalation training on how to diffuse situations before segregation becomes a consideration;
- Prohibit misbehavior reports for prisoners in RTP who refuse treatment or medication;
- Prohibit sanctioning of misconduct that occurs while a prisoner is in a RTP;
- Establish a monitoring system, including quarterly reports to the public—concerning the status of segregation units, RTPs, and CBPs—to offer information which will help in making reform efforts more effective; and
- Require monthly feedback from all MDOC employees about the status of programs, how the official feels they are working, and what changes can be made to better the system or program.

These suggestions, along with the author’s original proposals,\textsuperscript{284} are not something the MDOC can implement overnight, even if it wanted to. Therefore, this reform will likely take three to five years to fully implement. However, that does not mean immediate changes, which can increase the safety of the prisoners and prison, cannot be started now—such as eliminating Administrative Segregation for mentally ill and juvenile prisoners. Then as time progresses, MDOC can continue to reform its Administrative Segregation practices and policies to better reflect the suggestions in this Note, because they are truly designed to fit the mission statement of the MDOC and its goals of Administrative Segregation.

CONCLUSION

The detrimental effects of solitary confinement and isolation extend back to the inception of the practice itself.\textsuperscript{285} From early experiments, mental illness was shown to be a prevalent effect resulting from prolonged isolation.\textsuperscript{286} But these effects are found to be exacerbated in juveniles and prisoners already suffering from mental illness.\textsuperscript{287} Despite these findings, and a growing trend of reform across the country, the MDOC nonetheless

\begin{itemize}
  \item \textsuperscript{284} See supra Section V.
  \item \textsuperscript{285} See supra Section I.
  \item \textsuperscript{286} Dickens, supra note 8.
  \item \textsuperscript{287} See supra Section III.
\end{itemize}
continues to subject prisoners with mental illness and juveniles to this deleterious punishment.  

The MDOC’s Administrative Segregation policies and practices should be reformed to better reflect a correction system which seeks to punish offenders while maintaining maximum safety, and promoting prisoners’ rehabilitation. In doing so, MDOC should eliminate Administrative Segregation as a possible sanction for prisoners with mental illness and youths under twenty-one. This would protect the fragile mental health and cognitive states many of these prisoners suffer from. Additionally, creating transition units between Administrative Segregation and general population will not only help prisoners adjust more easily back into everyday functioning, but would also address the specific effects prisoners are known to suffer from upon exiting Administrative Segregation units. Also, these units would ensure that Administrative Segregation is reserved for only the most violent, and dangerous offenders. Furthermore, special programs, such as Residential Treatment Programs, need to be created to effectively rehabilitate youths and prisoners with mental illness by being specifically designed to treat, punish, and develop these prisoners in a more personalized way; recognizing the most effective sentence is one that addresses the actual issues these prisoners suffer from.

In conclusion, the MDOC should adopt these recommendations, as well as the recommendations in the “Youth in Prison Package,” and reform its Administrative Segregation practices to stop juveniles and prisoners with mental illness from feeling like caged animals, who would rather die than be subjected to the torture of complete isolation. Ultimately, the suggestions proposed in this Note not only better reflect the majority of states who have chosen to reform their Administrative Segregation policies; but actually resemble what the MDOC’s mission statement and goals of Administrative Segregation are—holding offenders accountable and promoting their rehabilitation through effective administrative management, maximum disciplinary control, and individual prisoner protection.

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288. See Segregation Standards, supra note 33.
289. See supra text accompanying pp. 351–52.

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