August 10, 2015

VIA U.S. MAIL AND EMAIL

Vanita Gupta
Principal Deputy Assistant Attorney General
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Ave NW
Washington, DC 20530

RE: Solitary Confinement in North Carolina Prisons

Dear Ms. Gupta,

On any given day, as much as 14 percent of North Carolina's 37,500 prison inmates are locked away in solitary confinement—often for such minor offenses as using profanity. There, they are isolated for 23 to 24 hours a day, without sunlight, fresh air, or contact with human beings. More than one in five of those prisoners placed in isolation require some type of treatment for mental health issues.

Understaffed, underfunded, and plagued by arbitrary standards, insufficient oversight, and inadequate resources for inmates with mental illness, North Carolina's solitary confinement regime must change. However, governmental efforts and calls from the media and the public have resulted in little meaningful reform. Every day that the status quo endures without intervention, North Carolina's system for housing inmates in solitary confinement claims more victims to needless suffering and death.

With this letter, North Carolina Prisoner Legal Services, the American Civil Liberties Union of North Carolina, the American Civil Liberties Union's National Prison Project, the University of North Carolina School of Law Human Rights Policy Seminar and Center for Civil

Rights, and North Carolina Stop Torture Now chronicle the deaths of Michael Kerr and other inmates and the mistreatment of countless more. These stories are not outliers but rather evidence of a profoundly misguided isolation regime. In turn, we note that this system and its scope can only be understood as a direct consequence of the state's disinvestment from community mental health services. Finally, in calling for the Department of Justice to meet with our organizations and open an investigation into the use of solitary confinement in our state's correctional institutions, we highlight that North Carolina has failed to adopt consequential reforms despite its recognition that the system is in crisis.

Death of Michael Kerr

On March 12, 2014, Michael A. Kerr died of dehydration en route from Alexander Correctional Institution (Taylorsville) to the prison hospital located at Central Prison (Raleigh). Ex. A, Letter to Shawn Blackburn Re: Final Agency Decision at 6 ("Final Agency Decision"). Mr. Kerr, a 53-year-old former Army sergeant with a diagnosis of schizoaffective disorder, had been locked in isolation since early February 2014. Joseph Neff, *NC Agencies Lock Down Info on Inmate's Death from Dehydration*, News & Observer (Nov. 8, 2014) ("Neff, *Death from Dehydration*"). He was in isolation as punishment for a series of minor disciplinary infractions that he had incurred since he went off his psychotropic medication in September or October 2013 while incarcerated and under the care of prison doctors. Ex. A, Final Agency Decision at 1-2. As additional punishment for his infractions, Mr. Kerr was placed on a Nutraloaf diet for several weeks during his isolation. *Id.* at 1.

The timeline of Mr. Kerr's death reveals a gruesome ordeal. In the days leading up to March 7, 2014, Mr. Kerr was reportedly not eating and covered in feces. *Breaking: New Evidence of Neglect and Abuse in the Death of NC Prisoner Michael Kerr*, Prison Books Collective (Apr. 16, 2014) *available at* http://bit.ly/1Lu4rwI. On March 7, 2014, Mr. Kerr was supposed to receive an injection per doctor's orders. Ex. A, Final Agency Decision at 4-5. The Officer in Charge, however, refused to comply with the physician's order. *Id.* On March 8, 2014, Mr. Kerr was restrained for a brief medical evaluation by medical staff. *Id.* at 1. When the evaluation concluded, he was left in handcuffs inside his isolation cell. *Id.*

Around this time and as a result of his being off of his medication, Mr. Kerr began pouring water on the floor of his cell. Neff, *Death from Dehydration*. "Come on in, the water is fine," he said. *Id.* This was treated as an inmate flooding his cell and, as a result, prison authorities turned off the water to his cell. *Id.*

On March 9, 2014, the Officer in Charge and a psychologist entered Mr. Kerr's cell and talked with him about removing the handcuffs. Ex. A, Final Agency Decision at 2. However,

the handcuffs were not removed, and Mr. Kerr received no medication. *Id.*

By March 12, 2014, Mr. Kerr was still locked in handcuffs and his water was still off. *Id.* The Officer in Charge found Mr. Kerr with his pants and underwear around his ankles. *Id.* He had urinated and defecated on himself. *Id.* Staff finally attempted to remove the handcuffs, which had now been on Mr. Kerr for five days. *Id.* Because the lock was clogged with dried feces, staff used bolt cutters to cut the handcuffs. *Id.* Mr. Kerr was not ambulatory, and could not even sit up upright in a wheelchair. *Id.* At one point, he fell out of the wheelchair. *Id.* Instead of sending Mr. Kerr to a nearby hospital, however, staff prepared Mr. Kerr for transfer to the hospital at Central Prison, some three hours away in Raleigh. *Id.* A corrections officer reported that Mr. Kerr's last word, as he was being loaded into the van for transport, was "Please." Tyler Dukes, *One Year Later, Inmate's Death Looms over State Prison Mental Health Debate*, WRAL (Mar. 12, 2015). He left Alexander Correctional Institution at 8:30 a.m. on March 12, 2014, and arrived at Central Prison at 11:30 a.m. Ex. A, Final Agency Decision at 2. By that time, he had died of dehydration. *Id.* Prison officials drove past eight hospital emergency rooms on the way to Central Prison, but did not stop to obtain care for Mr. Kerr. Neff, *Death from Dehydration*.[1]

The treatment that led to Mr. Kerr's horrific death is not an isolated episode; such neglect is in fact routine for many inmates with mental illness in North Carolina's state prison system. When inmates misbehave—even when it is symptomatic of mental illness—they are sent to segregation, where they are isolated between 23 and 24 hours a day. The due process they receive is cursory at best. When inmates further misbehave, they are sometimes placed in restraints, restricted to a Nutraloaf diet, subjected to pepper spray, or denied access to water. These harsh and isolating conditions cause inmates' mental health to deteriorate. Their deteriorating mental health leads to more infractions. And the infractions lead to longer stays in isolation—stays that often extend to years without proper review processes.

Facts about North Carolina's Isolation Regime

As of October 10, 2014, the North Carolina prison population was 38,095. Ex. B, 2014 Report of DPS Consultant Dr. Jeffrey L. Metzner at 2 ("2014 Metzner Report"). Forty-four of North Carolina's 56 state prisons have isolation cell blocks. Ex. C, 2015 Application for Technical Assistance to Vera Institute for Justice at 10 ("Application"). North Carolina reported

[1] On July 20, 2015, the State of North Carolina agreed to pay the estate of Mr. Kerr $2.5 million in compensation for the mistreatment that resulted in his death. Joseph Neff, *NC Reaches $2.5 Million Settlement with Estate of Inmate Who Died of Thirst*, News & Observer (July 20, 2015). As part of the settlement process, the North Carolina Attorney General's office produced a memo examining the State's potential liability for the death of Michael Kerr. The memo stated that the State's liability was "inescapable" because "Mr. Kerr's death was the direct result of multiple, flagrant errors committed by various Alexander Correctional staff members." Tyler Dukes, *AG Memo: State's Liability for Inmate Death 'Inescapable'*, WRAL (July 24, 2015).

that approximately 12% of the total inmate population receives some form of mental health treatment. Ex. B, 2014 Metzner Report at 2. In a report on the state of mental health care in North Carolina prisons, Dr. Jeffrey L. Metzner noted that this number is likely low with regard to the number of prisoners in need of mental health care. *Id.*[2] In fact, a 2007 memo from the North Carolina Department of Corrections' Office of Research and Planning revealed that the percentage of incarcerated individuals diagnosed with mental disorders in a given year (56%) is more than double that for non-institutionalized populations (26.2%). Ex. D, North Carolina Department of Corrections, *Mental Health Diagnoses in the Prison Population* (Aug. 2007) ("2007 DOC Report"). It further reported that the percent of female inmates diagnosed with mental illness in a given year (73%) is nearly triple that of the general population. *Id.* The discrepancy in the reported prevalence of mental illness may be based on poor diagnostic and screening mechanisms within the prison system.

About 14% of the total prison population is held in 23 to 24-hour isolation. Ex. C, Application at 28. Public records show that as many as 35% of youth (15, 16- and 17-year-olds) incarcerated in adult prisons are held in some form of solitary confinement.[3] Inmates held in disciplinary and administrative segregation represent more than half of the inmates in isolation. Ex. C, Application at 28. These are short-term statuses that typically last between 15 and 60 days. Ex. G, Disciplinary Segregation Policy at 5-7; Ex. H, Administrative Segregation Policy at 1-2. About a third of the total prison population is routinely placed in isolation for disciplinary infractions and investigations. Ex. C, Application at 30.

North Carolina refers to its long-term isolation regime as a "Control Status." Ex. I, Control Status Policies. An inmate's Control Status is reviewed every six months, and it may be continued indefinitely. *Id.* Many inmates remain on Control Status for years at a time. There are three levels of Control Status—High Security/Max Control (HCON), Maximum Control (MCON), and Intensive Control (ICON). *Id.* About 20% of the long-term isolation beds are

[2] Most systems report higher percentages, for example, North Carolina jails report that at least 23% of inmates have mental health issues. Ex. E, *Mental Illness and Substance Abuse in County Jails*, North Carolina Sheriff's Association at 2 (Dec. 11, 2014).

[3] On July 30, 2015, 28 of 79 youth (35.4%) incarcerated in adult prisons were being held in solitary. Segregation has also been widely used in youth facilities. From July 1, 2014 to June 30, 2015, a total of 541 juveniles were held in some form of solitary confinement in the six North Carolina Juvenile Detention Centers. During that same time period, 440 youth were held in solitary confinement in the State's four Youth Development Centers. At one Youth Development Center, C.A. Dillon (Butner, NC), the average length of stay in disciplinary segregation was 3.89474 days. These numbers do not include youth that may have been held in solitary confinement in North Carolina's three County Detention Centers. Ex. F, Public Records Request for DPS. "The overwhelming research that isolation, and particularly prolonged solitary confinement, can cause serious mental health-trauma, re-traumatization, depression, anxiety, psychosis, suicide, self-harm, violence and negatively impacts education, rehabilitation, physical health, family involvement and social development prompted the American Academy of Child and Adolescent Psychiatry (AACAP) to develop a policy statement opposing the use of prolonged isolation... There is no research showing the benefits of using isolation to manage youths' behavior." Ex. K, Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation at 4 (Mar. 2015).

filled by inmates receiving mental health treatment. Ex. B, 2014 Metzner Report at 2. Again, because of North Carolina's poor diagnostic and screening mechanisms, this number is likely low with regard to prisoners in need of such treatment. Strikingly, 31% of inmates released from isolation are released directly back into the community. Ex. C, Application at 29.

Officials at an inmate's facility initiate a referral to Control Status. Ex. I, Control Status Policies. The referral is reviewed by the Director's Classification Committee (DCC). *Id.* The inmate is given notice of the DCC hearing 48 hours in advance. *Id.* The written notice is supposed to reasonably inform the inmate of the reasons he or she is being considered for a Control Status. *Id.* However, practice does not comply with the policy. A typical DCC referral form will say: "Specific reason/rationale: Possible HCON housing." Ex. J, DCC Referral Forms. A typical summary of evidence will say: "Summary of evidence: recommendation for placement on HCON housing." *Id.* In other words, an inmate is given no meaningful explanation or justification for his or her referral at all. Although a mental health provider must sign-off on an inmate's assignment to HCON, inmates with serious mental health disorders are frequently assigned there based on only perfunctory assessments. One prisoner reported that her assessment included having her blood pressure taken and a query about prior injuries but no mental health assessment. Ex. L, *Solitary Confinement as Torture*, University of North Carolina School of Law Immigration/Human Rights Clinic at 26, 34-35 (2014) ("UNC Report").

The conditions of confinement for the Control Statuses are harsh.[4] They can be summarized as follows:

- Inmates are held in a small single cell with a bed, a small desk bolted to the wall, a shelf, a combination sink/toilet, and a sliver of a window.

- At Central Prison, the cells are 72 square feet in size, and the windows are covered in grimy metal grating that blocks light and vision.

- Doors are opened remotely by correctional officers in a control booth pushing a button.

- Inmates eat in their cells, receiving their meals through a slot in the door.

- To leave the cell, inmates must submit to handcuffs through the slot in the door. Inmates are moved in handcuffs, leg-cuffs, and waist irons with an escort of two to three officers.

[4] The conditions for individuals held in Disciplinary Segregation and Administrative Segregation are substantially similar to the conditions for those subject to the MCON or ICON Control Status. Those in Disciplinary segregation are not permitted visitors, nor radios. Ex. M, Conditions of Confinement Policy.

- In HCON, inmates are in their cell 24 hours a day and receive absolutely no human contact.

- In HCON, an inmate showers inside his or her own cell. An officer turns on the shower remotely three times a week for 10 minutes.

- In HCON, an inmate "recreates" in a cell adjacent to his or her own cell. Correctional officers open their door remotely and they are permitted to move into the recreation cell. With this arrangement, the inmate requires no escort and there is no human contact.

- In HCON, an inmate never goes outside or experiences fresh air.

- In MCON and ICON, an inmate is in his or her cell between 23 and 24 hours a day. They receive no human contact other than the occasional staff escort.

- In MCON and ICON, an inmate recreates in a cage five times a week for an hour at a time if there is sufficient staff on duty. Two times a week this is done outside. Three times a week it is done inside. He or she is chained and escorted to recreation by staff.

- In MCON and ICON, an inmate showers three times a week for 10 minutes at a time. He or she is restrained and then escorted to the shower by staff.

- An inmate may be denied recreation or a shower if he or she "refuses to comply with control procedures." This decision as to what constitutes "refusal to comply" is solely within the discretion of correctional staff and does not require notice to the inmate or a hearing.

- An inmate may be forced to recreate or shower while in full restraints at the discretion of correctional staff.

- An inmate who floods their cell may have his or her water turned off without safeguards for physical needs and regardless of mental health needs that may have triggered the flooding.

- Inmates' canteen privileges are limited. They may purchase a radio with headphones, a watch, shower shoes, postage stamps, limited over-the-counter medication, and three radio batteries per week.

- Radios may be confiscated without prior notice by the officer in charge of the institution "if necessary to maintain order and control."

- Hygiene kits and feminine supplies are provided by the facility every 30 days. Inmates complain that there are not enough supplies to last 30 days.

- Inmates may keep up to two cubic feet of personal property including legal papers, books, magazines, and religious paraphernalia.

- Inmates on Control Status are entitled to two visits every 30 days—unless they have recently been written up for an infraction, in which case the visits are prohibited.

- Inmates may not use the telephone.

- Inmates may not use a television.

- Inmates may not participate in religious programming or other activities.

- Inmates may not receive any sentence credits.

Ex. M, Conditions of Confinement Policy.

One of Control Status isolation units with a record of housing dozens of mentally ill inmates is the MCON Unit at Central Prison (Raleigh); it goes by the name of "Unit One." As part of a 2012 assessment of mental health care at Central Prison, Dr. Metzner evaluated Unit One. He found that 23% of the Unit One inmates were on the mental health caseload, most of whom were prescribed psychotropic medication. Ex. N, 2012 Report of DPS Consultant Dr. Jeffrey L. Metzner at 9 ("2012 Metzner Report"). He found that there were frequent and repeat admissions and discharges between Unit One and the Central Prison Mental Health Hospital. *Id.* at 10. In 2012, there were 23 Unit One inmates who were admitted to the Mental Health Hospital two times, 12 inmates who were admitted to the Mental Health Hospital three times, and 11 inmates who were admitted four or more times. *Id.* He reported that mental health rounds were not conducted within the isolation unit. *Id.* He found that two of the probable causes of the repeat admissions to the Mental Health Hospital were (1) inadequate mental health treatment being provided in Unit One, and (2) harsh conditions of confinement exacerbating an inmate's mental health condition. *Id.*

Subsequent to Mr. Kerr's death and at the request of advocacy organizations, Dr. Metzner returned to Unit One in 2014. He found that the prison had made little progress in the intervening years. Ex. B, 2014 Metzner Report at 10-11. It remained "problematic from a physical plant perspective related to the size of the cell (72 sq. ft.) and very little natural lighting." *Id.* at 12. Indeed, two inmates, Guanhui Lei and Edward Campbell, have committed suicide in Central Prison during the past 16 months. *Man Jailed for Murdering Wife, Pregnant*

Sister Found Hanging in Cell, MyFox8 (Feb. 7, 2014); *Man Charged with Killing Granville County Couple Commits Suicide in Raleigh Prison*, ABC11 (Mar. 11, 2015). The number of attempted suicides is unknown.

While inmates with mental illness are locked in isolation, they receive one check-up with psychological services every 45 days. Ex. N, 2012 Metzner Report at 10. These check-ups are conducted at the cell, with the provider yelling through the inmate's food trap. *Id.* at 15, 19. There is no confidentiality maintained. *Id.* These inmates receive no meaningful ongoing therapy or out-of-cell treatment modalities.

Unit One has recently been the subject of lawsuit related to excessive use of force. Ex. O, Complaint in *Corbett v. Branker*, No. 5-13-CT-3201-BO ("Complaint"). The lawsuit alleged that officers were taking advantage of "blind spots" in the unit to administer excessive force. *Id.* at ¶¶ 16-19, 23-24. The "blind spots" were areas without video surveillance. *Id.* John Davis was one plaintiff with mental illness in the case. He was diagnosed with schizoaffective disorder prior to his incarceration; he was classified as having a Mood Disorder, Not Otherwise Specified (NOS) in prison. Ex. P, Davis Medical Records. In his Declaration, Mr. Davis, who was also diabetic, reported that guards did not deliver his evening meal. Ex. Q, Declaration of John L. Davis. In protest, Mr. Davis began to shout and bang on his cell door. *Id.* Officers removed him from his cell, took him to an area nicknamed "the desert," and beat him while shackled, breaking his ribs. Ex. O, Complaint. Then, the officers put him back in the cell, denying him medical attention until the shift change. *Id.* Mr. Davis settled his claim out of court.

Inmate Stories

Unfortunately, as the below snapshots make plain, Mr. Kerr and Mr. Davis are far from the only inmates who have suffered because of substandard mental health treatment in the isolation units. The following accounts, in addition to those documented in a 2014 report by the UNC School of Law Immigration/Human Rights Policy Clinic,[5] paint a picture of a system in crisis. Ex. L, UNC Report.

JW:

JW is a mentally-ill inmate who has spent years on Control Status. Since 2006, he has lived the majority of his days on the MCON Unit at Central Prison (Unit One), interrupted by occasional transfers to the acute Mental Health Hospital. On Unit One, he is locked in a dim, 72-

[5] The report examined qualitative and quantitative data regarding the use and consequences of solitary confinement, explored substantive legal policy issues about the use of solitary, and offered recommendations for reforms. The report ultimately concluded that "solitary confinement is ineffective at decreasing violence within prisons; it is ineffective at preserving public safety; it is ineffective at managing scarce monetary resources; and it violates the boundaries of human dignity and justice." Ex. L, UNC Report at 2.

square-foot cell between 23 and 24 hours per day. The narrow window in the cell is covered with a metal grating that renders it impossible to see through. JW stated: "The first time you get locked up [in solitary confinement], it about drive (sic) you wild. You want to do anything to get out, even kill yourself." JW was diagnosed with paranoid schizophrenia in 1977, and has been homeless since 1979. He is incarcerated as a Habitual Felon, a status he earned after years of crimes primarily motivated by hunger and homelessness.

The symptoms of JW's schizophrenia include paranoid ideations and auditory and visual hallucinations. A prison psychiatrist has noted that JW "has serious mental illness which sometimes leads to poor reality testing, increased agitation & difficulty appreciating consequences." JW recognizes that his mental health has deteriorated since being housed on Unit One, remarking that whereas he used to talk to himself for minutes at a time, he now talks to himself for hours at a time. Notwithstanding these symptoms, JW is punished for misbehavior as though he is fully able to appreciate consequences. Moreover, when he throws liquids, kicks on his door, blocks the food trap, or uses profane language—all manifestations of his mental illness—he is often subjected to high concentration Oleoresin Capsicum pepper spray. Officers spray him through the trap door to his cell. *See generally* Ex. R, JW Medical Records.

CW:

Prison officials state that they perform mental health screenings before sending inmates to the harshest conditions of the HCON Unit at Polk Correctional, where prisoners are isolated 24 hours a day and never permitted to go outside or experience human contact. CW, however, was cleared for an HCON assignment, notwithstanding his diagnosis with an unspecified psychotic disorder and his daily prescription for Thorazine. His symptoms include auditory hallucinations, paranoia, agitation, and psychosis. Unsurprisingly, when he was sent to the extreme sensory deprivation of HCON, his mental health deteriorated even further. He attempted to hang himself multiple times until officials eventually sent him for a brief stay in the acute Central Prison Mental Health Hospital. He now lives in isolation again on Central Prison's Unit One. *See generally* Ex. S, CW Medical Records.

MW:

MW has cycled between the HCON Unit at Polk Correctional Institution, Unit One (the MCON Unit at Central Prison), and the Central Prison Mental Health Hospital since 1999. He has been admitted to the Mental Health Hospital over 30 times in the past 15 years. The rest of the time he has been in Control Status isolation housing. He has been diagnosed with Borderline Personality Disorder, Antisocial Personality Disorder, Attention Deficit Hyperactivity Disorder, Dysthymic Disorder, and Major Depressive Disorder. His intellectual limitations include Borderline Intellectual Functioning and Mild Mental Retardation. MW's mental illness

primarily manifests as extreme self-injurious behavior, including self-laceration, insertion of foreign objects into his body, including his penis, banging his head, and swallowing foreign objects. The prison only keeps MW at the Mental Health Hospital long enough to stabilize him, and then returns him to Control Status isolation housing, where he deteriorates and begins injuring himself anew. Then, he is eventually returned to the Mental Health Hospital. He reports that his doctors have told him he should be permanently retained at the Mental Health Hospital, but there are insufficient beds to do so. *See generally* Ex. T, MW Summary of Medical Records.

RD:

RD has a history of behavioral and mental health problems dating to childhood. He has limited cognitive ability and high impulsivity. He is a long-term resident of the isolation unit at Alexander Correctional Institution. His diagnoses have changed repeatedly; they include Mood Disorder Induced by Head Trauma, Psychotic Disorder NOS, Intermittent Explosive Disorder, and Antisocial Personality Disorder. RD is serving an additional 77-102 months in prison as a result of behaviors that relate directly to his mental illness. After burning toilet paper in his isolation cell in 2011, the prison pressed criminal charges against him. He was indicted for "burning personal property," and he was charged as a Habitual Felon. Although RD extinguished the small toilet paper fire before he was removed from his single cell, he was convicted of "burning personal property" after a jury trial. He tried to plead guilty to the Habitual Felon charge in order to take advantage of a plea deal that would have given him a reduced sentence. However, the judge found that RD did not understand what was going on and was incompetent to enter a plea deal. He was sentenced to a greater term than the plea deal would have specified. It is likely that he will spend the entirety of his 77-102 month sentence on a Control Status. *See generally* Ex. U, RD Medical Records.

A System in Crisis

The high percentage of inmates with mental health diagnoses—like those described above—is largely traceable to more than a decade of decline in community mental health services in North Carolina. Today, the prison system is the largest provider of mental health care in the state and is ill equipped to meet the needs of its inmates.

How We Got to Today's Crisis: The Decline of Community Mental Health Services

In 2001, North Carolina undertook a massive effort to reform mental health care, including the privatization of many mental health services and the creation of regional management entities that replaced local county mental health agencies. The vision, captured in North Carolina's DHHS *State Plan 2001: A Blueprint for Change*, emphasized the need to

provide meaningful integrated services in accessible community settings for adults with severe and persistent mental illness. Ex. V, State Plan 2001: Blueprint for Change.

Instead of providing meaningfully integrated services, however, this experiment has wreaked havoc on North Carolina's mental health system over the last decade and a half. In 2008, 25 of North Carolina's 100 counties had no practicing psychologists; an additional 15 counties had only one practicing psychologist.[6] Ex. W, Alison Gray, *Reforming Mental Health Reform: The History of Mental Health Reform in North Carolina* at 67 (Mar. 2009). The service delivery system has been in constant flux since 2001. For people needing help, the system is fractured, chaotic, and difficult to navigate. Mental health and developmental disability systems are siloed. Provider requirements and the means of accessing services frequently change. And authorized services are often time-limited and inadequate. Little wonder a "sense of crisis [pervades the system] due to the frustration many feel when failures and breakdowns in the system become apparent and when lives are affected." Thomas C. Ricketts, *Policy Forum: North Carolina's Evolving Mental Health System*, 73 North Carolina Medical Journal, 176 (May/June 2012).

The failures of this experiment have been known by the state for years. In November 2013, the North Carolina Division of Mental Health, Developmental Disability and Substance Abuse Services admitted,

> The current mental health crisis system is a reactionary one and lacks the alternative resources needed to help individuals and their families access help during crisis episodes. The result is high level of ED [emergency department] usage, extended wait times in an ED, repeated visits to the ED, increased incidence of mental illness in jails and prisons and higher costs.

Ex. X, Crisis Solutions Initiative: White Paper on Mental Health Crisis Solutions. Despite this recognition, the reality remains largely unchanged.[7] Due to the constant shifting and limiting of

[6] Similarly, a 2004 study found that there were 17 counties in North Carolina with no psychiatrists. These counties are concentrated in far eastern and far western North Carolina, resulting in large swaths of the state having little to no community resources. "Another 27 counties have fewer than .33 psychiatrists per 10,000 population, the level required for federal designation as a mental health professional shortage area." Erin Fraher et al., *The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform* 3 (2006).

[7] A Scorecard issued by the Crisis Solutions Initiative found that, rather than diminishing, the number of ED admissions for those with primary mental health diagnoses went up slightly from 2013 (3.2% of total ED admissions) to 2015 (3.9% of total admissions). The Scorecard also showed that that average wait times in the ED went up (from 3.52 days in 2013 to 4.19 days in 2015) and that the number of readmissions to EDs within 30 days also increased (from 13% in 2012 to 14.8% in 2014). Ex. AA, Crisis Solutions Initiative Scorecard.

services, many North Carolinians with mental illness end up in our jails and prisons. *See generally*, Ex. Y, NAMI Wake County, *Prisons and Jails are North Carolina's New Mental Hospitals*, (Oct. 12, 2010).

Papering Over the Crisis: Repeated Acknowledgment, Inadequate Response

Today North Carolina's jails and prisons house more people with mental illness than our state psychiatric hospitals.[8] Ex. Z, Treatment Advocacy Center, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey (abridged)* at 4 (Apr. 8, 2014). Since at least 2007, North Carolina has known of and documented the growth of mental health disorders in the prison population. Ex. D, 2007 DOC Report. In 2011 an internal audit of Central Prison detailed the squalid conditions in which prisoners with mental illness were left ignored and un-medicated in solitary confinement, Ex. BB, Interim Summary: "Old" Central Prison Inpatient Mental Health Review. And, yet, today prison rules, procedures, culture and staffing remain inadequate to safely care for the influx of inmates with mental illness. Billy Ball, *Prison System Short on Psychologists, Long on Mentally Ill Inmates*, Indy Week (Nov. 5, 2014).

State officials have taken some steps in recent years in response to advocates' outcries, Ex. CC, 2011 Petition for Redress of Grievances. Among other things, the Department of Corrections has consulted twice with Dr. Metzner (after the 2011 internal audit became public and after Mr. Kerr's death) and was selected to receive technical assistance from the Vera Institute as part of its Safe Alternatives to Segregation initiative.

These measures, however, are not adequate to address the breadth of this constitutional problem. Notwithstanding calls for reform, no prisoner with mental illness has ever been removed from solitary confinement before an acute manifestation of their illness, such as an act of self-harm or an attempted suicide. Today, inmates with mental illness continue to be placed and remain in solitary confinement without adequate treatment. They are disciplined for manifestations of their illness, and they are released directly to the community after months or years in isolation. Despite the deaths of Mr. Kerr, Mr. Lei, and Mr. Campbell, and daily human suffering and injury, the prison system has not changed its policy or practice on isolation of inmates with mental illness.

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[8] While this letter focuses on North Carolina's prisons, the experience in our jails reinforces the consequences of the evisceration of community health services in the state. The North Carolina Sheriff's Association presented informal survey numbers to the Oversight Committee on Justice and Public Safety of the North Carolina General Assembly on December 11, 2014, reporting that 23% of jail inmates have mental illness, but acknowledged "that the numbers were likely unreliable and possibly seriously understated." Ex. E, North Carolina Sheriff's Association, *Mental Illness and Substance Abuse in County Jails*, (Dec. 11, 2014); North Carolina Association of County Commissioners, Blog, *JPS Oversight Committee Hears about Mental Health Issues in Jails* (Dec. 12, 2014) *available at* http://ncacc.org/blog.aspx?iid=182; Renee Elder, *Better Mental Health Treatment is Key to Reducing Jail Population, study says*, News & Observer (June 24, 2013) (reporting that "About 60% of the 1,345 inmates in the Wake County Jail have some type of mental illness").

Subsequent to Mr. Kerr's shocking death, there has been discussion of providing additional funds for prison mental health services. Governor McCrory requested $24 million for this purpose in the 2015-16 fiscal year budget he presented to the General Assembly. The North Carolina House halved the Governor's proposal. The North Carolina Senate, in turn, halved the House's proposal. If $6 million is the legislative response immediately following a mentally ill inmate dying of dehydration and months of press scrutiny thereof, then the long-term prospects for addressing this crisis once the cameras have moved on are gloomy indeed. Division of Adult Correction and Juvenile Justice Commissioner W. David Guice has stated he is ready to make the needed reforms, but that will not be possible without a broader cultural shift acknowledging the current state of crisis and funding commensurate to its scale. Laura Leslie, *DPS seeks $20M for Prison Mental Health*, WRAL (Dec. 11, 2014).

Conclusion

In his July 14, 2015, speech to the National NAACP Convention, President Obama said he has asked Attorney General Loretta Lynch to begin a review of "the overuse of solitary confinement" in American prisons. "The social science shows that an environment like that is often more likely to make inmates more alienated, more hostile, potentially more violent," President Obama explained. "Do we really think it makes sense to lock so many people alone in tiny cells for 23 hours a day, sometimes for months or even years at a time? That is not going to make us safer. That's not going to make us stronger. And if those individuals are ultimately released, how are they ever going to adapt? It's not smart."

Mr. Kerr's death in North Carolina was the inevitable consequence of a broken mental health system flooding state prisons with the mentally ill and, in turn, a broken, inadequately funded means of managing such inmates. The conditions in our prisons are so dire that the aforementioned UNC School of Law Immigration/Human Rights Policy Clinic report concluded that they constitute torture. Mr. Kerr's death, along with myriad other signs of a system blinking red in the preceding decade, should have been the catalyst for real, immediate change. And, yet, despite the scathing Human Rights Policy Clinic report, two harshly critical reports by Dr. Metzner before and after the death of Mr. Kerr, thousands of column inches in state newspapers, and much hand-wringing from state officials, North Carolina's prison mental health and isolation regimes remain unchanged and its budget proposals in no way match the severity of the crisis. If not before, it is now obvious that North Carolina does not have the wherewithal or the will to solve this problem.

Therefore, we urge the Department of Justice to meet with our organizations and open an investigation into the dangerous and unconstitutional use of isolation in North Carolina prisons. Should you wish to discuss this issue further, please contact Elizabeth Simpson, staff attorney at

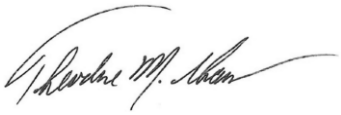
North Carolina Prisoner Legal Services or Christopher Brook, Legal Director of the American Civil Liberties Union of North Carolina. Ms. Simpson can be reached at 919-856-2200 or esimpson@ncpls.org. Mr. Brook can be reached at 919-834-3466 or cbrook@acluofnc.org. Thank you for your time and consideration of this important matter.

Sincerely,

Amy Fettig
Senior Staff Counsel
ACLU National Prison Project

Chris Brook
Legal Director
ACLU of North Carolina

Elizabeth Simpson
Staff Attorney
North Carolina Prisoner Legal Services



Theodore M. Shaw
Director of the Center for Civil Rights
University of North Carolina

Deborah Weissman
Reef Ivey II Distinguished Professor of Law
Human Rights Policy Seminer
UNC School of Law

Christina Cowger
Coordinator
North Carolina Stop Torture Now

cc: Thomas G. Walker, United States Attorney for the Eastern District of North Carolina