Testimony of Professor Craig Haney

House Judiciary Committee

Hearing on Solitary Confinement

March 5, 2024

Chairman Briggs, Chairman Kauffman, and distinguished members of the House Judiciary Committee: My name is Craig Haney. I am a Distinguished Professor of Psychology at the University of California, Santa Cruz, and someone who has been studying the psychological effects of solitary confinement for well over 40 years. My academic interest in prisons more generally began very early in my professional life. In 1971 I was one of the principal researchers in a widely publicized study that came to be known as the "Stanford Prison Experiment." My colleagues and I placed a carefully screened group of psychologically healthy college students in a prison-like environment, randomly assigning half to be guards, half prisoners. We observed with increasing concern and dismay as the behavior of the otherwise psychologically healthy volunteers in our simulated prison rapidly deteriorated into mistreatment and emotional breakdowns.[1] When I began to study real prisons, examining and evaluating conditions of confinement in prison systems throughout the United States and in a number of foreign countries, I continued to be guided by the early lesson of the Stanford Prison Experiment: prisons can unleash psychologically powerful, potentially destructive forces, ones that are capable of shaping and transforming the thoughts and actions of the persons who enter them, often in unintended and adverse ways.

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[1] For example, see: C. Haney, Curtis Banks & Philip Zimbardo, Interpersonal Dynamics in a Simulated Prison, 1 International Journal of Criminology and Penology 69 (1973); and C. Haney & Philip Zimbardo, The Past and Future of U.S. Prison Policy: Twenty-five Years After the Stanford Prison Experiment, 53 American Psychologist 709-727 (1998).

In the aftermath of the Stanford Prison Experiment, early in my study of "real" as opposed to "simulated" prisons, I observed the increasingly widespread use of a practice that that was commonplace in 19th century prisons but long-since had been abandoned—placing prisoners in solitary confinement for extended periods of time. Since then, I have toured and inspected solitary confinement units in correctional systems in more than half the states in the United States, from Maine to California, as well as many federal prisons, including the "supermax" in Florence, Colorado (ADX). I have conducted systematic psychological assessments of several thousand isolated prisoners, most of whom have been confined in solitary confinement units for periods of months, years, and even decades, during which time they have been kept separate from other prisoners, and denied the opportunity to have any normal human social contact or to engage in any meaningful social interaction.[2]

The Historical Context

As I noted above, although the increased use of isolated or solitary confinement in American prisons began in the late 1970s and early 1980s, it

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[2] Much of my professional access to conditions of solitary confinement and to the large number of prisoners and staff whom I have interviewed has occurred in the context of constitutional litigation in which I have been asked or appointed to help determine whether and how isolated prisoners were being subjected to potentially cruel and unusual punishment. For example, see, *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995); *Ruiz v. Johnson*, 37 F. Supp. 2d 855 (S.D. Tex. 1999); *Coleman v. Brown*, 28 F.Supp.3d 1068 (E.D. Cal. 2014); Johnson v. Wetzel, et al., 209 F. Supp. 3d (M.D. Pennsylvania, 2016) *Braggs v. Dunn*, 257 F. Supp. 3d 1171 (M.D. Ala. 2017); *Davis v. Baldwin*, WL: 2414640 (S.D. Ill 2021); *Tellis v. LeBlanc*, WL 67572 (W.D. La. 2022), and *Jensen v. Shinn*, 609 F. Supp.3d 789 (D. Arizona 2022).]. I was the principal author of the Brief of Professors and Practitioners of Psychology and Psychiatry as Amicus Curiae in *Austin v. Wilkinson*, 545 U.S. 209 (2005). This work has provided me with a rare opportunity not only to conduct in-depth inspections of numerous solitary confinement units and to interview a great number of prisoners and staff members who live and work there, but also to review an extensive number of prison documents, records, and files that pertain to the operation of the units themselves.

represented a return to a long-discredited practice that the nation had abandoned more than a century ago. As you may know, there was a time in our distant history when all prisons were operated as solitary confinement units, or nearly so. However, as the U.S. Supreme Court noted in an 1890 case, *In re Medley*, by the end of the 19th century, solitary confinement had already come to be known as an "infamous punishment," largely because, as the Court acknowledged: "A considerable number of the prisoners [in solitary] fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide, while those who stood the ordeal better were not generally reformed and in most cases did not recover sufficient mental activity to be of any subsequent service to the community."[3]

Indeed, the Court's *Medley* opinion echoed observations that had been made even earlier by Alexis d'Tocqueville, who concluded that solitary confinement in American prisons "devours [its] victims incessantly and unmercifully" and noted that the "unfortunate creatures who submitted to [it] wasted away,"[4] and by Charles Dickens, who, although himself no stranger to harsh and degrading conditions, termed solitary confinement a "dreadful" punishment that inflicted terrible psychic pain that "none but the sufferers themselves can fathom, and which no man has a right to inflict upon his fellow creatures."[5] As you may know, the comments have special historical relevance to Pennsylvania: both of these scathing observations were offered after each

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[3] *In re Medley*, 134 U.S. 160, 168 (1890).

[4] Quoted in Torsten Eriksson, The Reformers, An Historical Survey of Pioneer Experiments in the Treatment of Criminals. New York: Elsevier (1976), at 49.

[5] Charles Dickens, American Notes for General Circulation. London: Chapman and Hall (1842), at 119-20.

commentator had toured the Eastern State Penitentiary, then located on the outskirts of Philadelphia (and now the site of an informative prison museum).

I wish I could say that the nation's return to this long-discredited practice was occasioned by significant advances in the way that solitary confinement is now implemented, or that new psychological insights had emerged to lessen previously widespread concerns about its damaging effects. I cannot. Instead, I believe the renewed use of long-term solitary confinement is the result of the confluence of three unfortunate trends—the era of "mass imprisonment" that began in the mid-1970s and produced widespread prison overcrowding, the shift in responsibility for housing the mentally ill to the nation's prison systems, and the abandonment of the rehabilitative ideal and its corresponding mandate to provide prison programming and treatment. The renewed widespread use of solitary confinement emerged as an administrative stop-gap—an ill-advised but expedient measure to keep the resulting and potentially very problematic prison dynamics in check. I believe it has become increasingly clear that this approach to prison management has created far more problems than it solved (if, indeed, it ever solved any).

The Conditions of Solitary Confinement

The term "solitary confinement" is a term of art in corrections. Solitary or isolated confinement goes by a variety of names in U.S. prisons—Security Housing, Administrative Segregation, Close Management, High Security, Closed Cell Restriction, and so on. In Pennsylvania, they are commonly labelled Restricted Housing Units or "RHUs." But the units all have in common the fact that the prisoners who are housed inside them are confined upwards of 22 hours a day in typically windowless or nearly windowless cells that commonly range in

dimension from 60 to 80 square feet. The ones on the smaller side of this range are roughly the size of a king-sized bed or parking space, one that contains a bunk, a toilet and sink, and all of the prisoner's worldly possessions. Thus, prisoners in solitary confinement sleep, eat, and defecate in their cells, in spaces that are no more than a few feet apart from one another.

Beyond the physical limitations and procedural prohibitions that are central to solitary confinement units, these places must be "lived in," typically on a long-term basis. Reflect for a moment on what a small space that is not much larger than a king-sized bed or parking space looks, smells, and feels like when someone has lived in it for upwards of 22 hours a day, day after day, for months or sometimes years on end. Property is strewn around, stored in whatever makeshift way possible, clothes and bedding soiled from recent use sit in one or another corner or on the floor, the residue of recent meals (that are eaten within a few feet of an open toilet) here and there, on the floor, bunk, or elsewhere in the cell. Ventilation is often substandard in these units, so that odors linger, and the air is sometimes heavy and dank. In some isolation units, prisoners are given only small amounts of cleaning materials—a Dixie cup or so of cleanser—once a week, making the cells especially difficult to keep clean.

Inside their cells, units, and "yards," isolated prisoners are surrounded by nothing but concrete, steel, cinderblock, and metal fencing—often gray or faded pastel, drab and sometimes peeling paint, dingy, worn floors. There is no time when they escape from these barren "industrial"-like environments, that afford little or no contact with the natural world. Many prisoners sit back on their bunks, look around at what has become the sum total of their entire lives, hemmed in by the tiny, degraded space that surrounds them and, not surprisingly, become deeply despondent.

With very few exceptions, virtually all of the solitary confinement units with which I am familiar prohibit contact visits of any kind, and many even prohibit them for legal visits. This means that prisoners go for months or years—in some cases, for decades—never touching another human being with affection. Indeed, the only regular "interactions" that prisoners housed in these units routinely have occur when correctional officers push food trays through the slots on their doors two or three times a day in order to feed them. The only form of actual physical "touching" they experience takes place during the incidental contact that occurs when they are being placed in mechanical restraints—leg irons, belly chains, and the like—in a procedure that typically begins even before their cell doors are opened, as they are required to cuff up" by placing their arms back through the tray slots on their cell doors, which is done every time they are taken out of their cells by correctional staff, on the relatively infrequent occasions when this occurs.

When prisoners in solitary confinement units leave their cells for what is, typically, an average of one or two hours a day, it is usually to go to a so-called "yard." I say "so-called" because the "yard" in most of these units bears no relationship to the image this word ordinarily conjures. Instead, the yard to which persons in solitary confinement have access often consists of a metal cage, sitting atop a slab of concrete or asphalt or, in the case of California's Pelican Bay, or Arizona's SMU I, a concrete-enclosed pen, one surrounded by high solid walls that prevent any view of the outside world. The exercise cages typically lack exercise equipment (with the occasional exception of a pull up or dip bar), so prisoners mill about, do calisthenics by themselves, or walk in circles inside the caged perimeters. Federal Judge Thelton Henderson, who presided over a landmark case examining conditions of confinement at the Pelican Bay Security Housing Unit or "SHU," noted that the image of prisoners trying to exercise in

these concrete pens—their only regular opportunity to be out of their windowless cells each day—was "hauntingly similar to that of caged felines pacing in a zoo."[6] It is an apt description that unfortunately applies to many prisoners in many such "yards" around the country. In fact, the haunting similarities to zoos are not limited merely to the nature of the yards; one is hard-pressed to name any other place in our society where sentient beings are housed and treated the ways that they are in solitary confinement.

The emptiness and idleness that pervade most solitary confinement units are profound and enveloping. The prison typically provides the prisoners in these units with literally nothing meaningful to do. That emptiness, when combined with the total lack of meaningful social contact, has led some prisoners into a profound level of what might be called "ontological insecurity"—they are not sure that they exist and, if they do, exactly who they are. A number of prisoners have told me over the years that they actually have precipitated confrontations with prison staff members (that sometimes result in brutal "cell extractions") in order to reaffirm their existence.

The Makeup of Solitary Confinement Units

You are no doubt wondering who is confined in these units. That is, what does a prisoner have to do in order to be housed in such a place? In fact, some of the prisoners have done very serious things, including assaulting other prisoners or even staff members; some have even committed in-prison homicides. However, in most isolation units these prisoners are the exception rather than the rule. A number of prisoners are in solitary confinement for having committed an

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[6] *Madrid*, supra note 2, at 1229.

unacceptably high number of minor offenses, or because one egregious offense in their past continues to be used as the justification for their ongoing placement in solitary confinement, even if they have subsequently demonstrated conforming behavior for an extensive period of time.[7] An even larger number of persons are housed in solitary confinement because they are alleged to be prison gang members or associates, an offense that, in and of itself, can result in indefinite solitary confinement in some jurisdictions. This is true even though the prisoners in question may not have engaged in any overt rule violations other than their alleged connection to the gang, and may remain entirely free of disciplinary write-ups during the many years of their indefinite isolation. Although allegations of gang membership are inherently subjective and can be unreliable, prisoners who are erroneously classified in this way are hard-pressed to establish facts that might exonerate them and may be confined in isolation on an incorrect basis indefinitely.[8]

In addition, there are two very problematic but little publicized facts about the group of prisoners who are housed inside our nation's solitary confinement units. The first is that a shockingly high percentage of them are mentally ill, and often profoundly so. In some cases, the mental illness was pre-existing and may even have been the primary cause of the disciplinary infraction that brought them to the solitary confinement unit in the first place. In other instances, however, the

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[7] For example, in a relatively recent Pennsylvania case, Arthur Johnson was retained in isolation in the Pennsylvania Department of Corrections for approximately 36 years, despite the fact that he had, as then Secretary of Corrections Wetzel acknowledged, "stayed out of trouble in prison... [for] the last *twenty-five years*" [*Johnson v. Wetzel, et al.*, 209 F. Supp. 3d 766 (M.D. Pennsylvania), at 780 (emphasis in original)]. Notwithstanding Mr. Johnson's quarter century of good behavior, Secretary Wetzel refused to release him from solitary confinement into a mainline prison setting until he was ordered to do so by Federal District Court Chief Judge Christopher Conner. I testified as an expert witness on Mr. Johnson's behalf and provided the court with an assessment of the significant risk of serious psychological harm to which he was being exposed.

[8] For example, see: Erica Goode, Fighting a Drawn-Out Battle Against Solitary Confinement, New York Times, March 30, 2012. [available at: http://www.nytimes.com/2012/03/31/us/battles-to-change-prison-policy-of-solitary-confinement.html?pagewanted=all]

signs and symptoms of mental illness appear to have emerged only after the prisoner's term in solitary confinement began. Studies indicate that approximately a third or more of the prisoners in solitary confinement units suffer from mental illness.[9] In my experience, the figure is much higher; in many of the units that I have inspected and conducted interviews, half or more of the prisoners suffer from mental illness, as acknowledged and documented by the prison systems' own mental health staff. Approximately 50% of all prison suicides occur in solitary confinement units.[10]

The other very troublesome but rarely acknowledged fact about solitary confinement is that in many jurisdictions it appears to be reserved disproportionately for prisoners of color. That is, the racial and ethnic overrepresentation that occurs in our nation's prisons generally is, in my personal experience, even more drastic inside solitary confinement units. Although these data typically are not systematically collected and made available for analysis overall, a study that I conducted in a Security Housing Unit in

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[9] Specifically, two separate studies have found that 29% of the prisoners in solitary confinement suffer from a "serious mental disorder." Hodgins, S., and Cote, G., The Mental Health of Penitentiary Inmates in Isolation, 33 Canadian Journal of Criminology 177-182 (1991); Lovell, D., Cloyes, K., Allen, D., & Rhodes, L., Who Lives in Super-Maximum Custody? A Washington State Study, 64 Federal Probation 33-38 (2000). Lovell later reported that he and his colleagues found that, if the definition of mental illness is broadened to include "psychosocial impairments," then approximately 45% of solitary confinement prisoners he studied were "psychologically disturbed." D. Lovell, "Patterns of Disturbed Behavior in a Supermax Population," 35 Criminal Justice and Behavior 985 (2008), at p. 999.

[10] Mears, D.P. & Watson, J., Towards a Fair and Balanced Assessment of Supermax Prisons, 23 Justice Quarterly, 232 (2006); Way, B., Miraglia, R., Sawyer, D., Beer, R., & Eddy, J. (2005). Factors Related to Suicide in New York State Prisons, 28 International Journal of Law and Psychiatry, 207 (2005); Patterson, R.F. & Hughes, K., Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004, 59 Psychiatric Services 676-682 (2008). See, also: Cloyes, K., Lovell, D., Allen, D., & Rhodes, L. Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample, 33 Criminal Justice and Behavior 760-781 (2006).

California confirmed that approximately 90% of the prisoners housed there were of color (i.e., Latino or African American).[11]

The Psychological Effects of Solitary Confinement

What are the consequences of confinement in such harsh and deprived places? When Senator John McCain reflected on his mistreatment during his years spent as a prisoner of war, he characterized solitary confinement as "an awful thing," noting that: "It crushes your spirit and weakens your resistance more effectively than any other form of mistreatment. Having no one else to rely on, to share confidences with, to seek counsel from, you begin to doubt your judgment and your courage."[12] My observations of the effects of solitary confinement as it is practiced inside our nation's prisons are consistent with Senator McCain's. The level of suffering and despair in many of these units is palpable and profound.

As the federal judge who heard testimony about California's Pelican Bay Security Housing Unit concluded, the severe deprivation and oppressive control conditions in these places "may press the outer bounds of what most humans can psychologically tolerate."[13] For a number of prisoners, those bounds are greatly exceeded, and the consequences of their long-term solitary confinement are truly extreme. Serious forms of mental illness can result from these experiences. Moreover, many prisoners become so desperate and despondent that they engage

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[11] See discussions of this issue in: R. Sakoda & J. Simes, Solitary Confinement and the U.S. Prison Boom, Criminal Justice Policy Review 1-37 (2019); M. Schlanger, Prison Segregation: Symposium Introduction and Preliminary Data on Racial Disparities, 18 Michigan Journal of Race & Law 241-250 (2013).

[12] Quoted in Richard Kozar, John McCain: Overcoming Adversity. Chelsea House (2001), at p. 53.

[13] *Madrid*, supra note 2, at p. 1267.

in self-mutilation and, as I noted early, a disturbingly high number resort to suicide. Indeed, it is not uncommon in these units to encounter prisoners who have smeared themselves with feces, sit catatonic in puddles of their own urine on the floors of their cells, or shriek wildly and bang their fists or their heads against the walls that contain them. In some cases the reactions are even more tragic and bizarre, including grotesque forms of self-harm and mutilation—prisoners who have amputated parts of their own bodies or inserted tubes and other objects into their penises—and are often met with an institutional matter-of-factness that is equally disturbing.

I recall a prisoner in New Mexico who was floridly psychotic and used a makeshift needle and thread from his pillowcase to sew his mouth completely shut. Prison authorities dutifully unstitched him, treated the wounds to his mouth, and then not only immediately returned him to the same isolation unit that had caused him such anguish but gave him a disciplinary infraction for destroying state property (i.e., the pillowcase), thus ensuring that his stay in the unit would be prolonged. A prisoner at the federal supermax prison—ADX—who had no pre-existing mental disorder before being placed in isolation, suffered from severe mental illness for many years while confined there. During his time in solitary confinement, he amputated one of his pinkie fingers and chewed off the other, removed one of his testicles and scrotum, sliced off his ear lobes, and severed his Achilles tendon with a sharp piece of metal. Despite this egregious self-harming behavior, he was retained in a standard solitary confinement unit rather than being transferred to a psychiatric facility. Another prisoner I interviewed in long-term in a solitary confinement unit in Massachusetts, had a documented history of several times disassembling the television set in his cell and eating its contents. Each time, his stomach was pumped and, after a brief

stay in a psychiatric unit, he was returned to the same punitive isolation where this desperate and bizarre behavior had occurred.

Beyond these extreme cases, solitary confinement places all of the prisoners exposed to it at significant risk of serious harm. In fact, the scientific literature on the effects of solitary confinement has been accumulated over many decades, by researchers from a number of different countries who have varying academic backgrounds. Despite the methodological limitations that come from studying human behavior in such a complex environment, most of the research has reached remarkably similar conclusions about the adverse psychological consequences of solitary confinement. Thus, we know that prisoners in solitary confinement suffer from a number of psychological and psychiatric maladies, including: significantly increased negative attitudes and affect, irritability, anger, aggression and even rage; many experience chronic insomnia, free floating anxiety, fear of impending emotional breakdowns, a loss of control, and panic attacks; many report experiencing severe and even paralyzing discomfort around other people, engage in self-imposed forms of social withdrawal, and suffer from extreme paranoia; many report hypersensitivity to external stimuli (such as noise, light, smells), as well as various kinds of cognitive dysfunction, such as an inability to concentrate or remember, and ruminations in which they fixate on trivial things intensely and over long periods of time; a sense of hopelessness and deep depression are widespread; and many prisoners report signs and symptoms of psychosis, including visual and auditory hallucinations.[14] Many of these symptoms occur in and are reported by a large number of isolated prisoners. For

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[14] For citations to the studies in which these specific adverse effects have been reported, see: C. Haney, Mental Health Issues in Long-Term Solitary and "Supermax" Confinement, 49 Crime & Delinquency 124-156 (2003), and C. Haney, The Social Psychology of Isolation: Why Solitary Confinement is Psychologically Harmful, Prison Service Journal UK (Solitary Confinement Special Issue), Issue 181, 12-20 (2009).

example, in a systematic study I did of a representative sample of solitary confinement prisoners in California, prevalence rates for most of the above mentioned symptoms exceeded three-quarters of those interviewed.[15]

In addition to the above clinical symptoms and syndromes, prisoners who are placed in long-term isolation often develop what I have characterized as "social pathologies," brought about because of the pathological deprivations of social contact to which they are exposed. The unprecedented totality of control in these units occurs to such an exaggerated degree that many prisoners gradually lose the ability to initiate or to control their own behavior, or to organize their personal lives. Prisoners may become uncomfortable with even small amounts of freedom because they have lost confidence in their own ability to behave in the absence of constantly enforced restrictions, a tight external structure, and the ubiquitous physical restraints. Even the prospect of returning to the comparative "freedoms" of a mainline maximum security prison (let alone the free world) fills them with anxiety.

For many prisoners, the absence of regular, normal interpersonal contact and any semblance of a meaningful social context in these isolation units creates a pervasive feeling of unreality. Because so much of our individual identity is socially constructed and maintained, the virtually complete loss of genuine forms of social contact and the absence of any routine and recurring opportunities to ground thoughts and feelings in a recognizable human context lead to an undermining of the sense of self and a disconnection of experience from meaning. Some prisoners experience a paradoxical reaction, moving from initially being starved for social contact to eventually being disoriented and even frightened by it. As they become increasingly unfamiliar and uncomfortable with

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[15] See supra, note 14, Haney (2003).

social interaction, they are further alienated from others and made anxious in their presence. In extreme cases, another pattern emerges: this environment is so painful, so bizarre and impossible to make sense of, that they create their own reality—they live in a world of fantasy instead. Finally, the deprivations, restrictions, the totality of control, and the prolonged absence of any real opportunity for happiness or joy fills many prisoners with intolerable levels of frustration that, for some, turns to anger, and then even to uncontrollable and sudden outbursts of rage.

Over the decades during which I have studied the psychological and physical effects of solitary confinement, I have published several literature reviews that summarized the growing body of scientific research that was available at the time of the review. These published reviews are relatively readily available, and they include an early review that I published with my then-graduate student, now Professor Mona Lynch, in 1997,[16] another in 2003, that included a discussion of some of the systematic data that I collected in the solitary confinement unit Pelican Bay State Prison in California,[17] and another in 2018, which reviewed published research that appeared in print up to the year before the publication appeared.[18]

However, since then, the scientific literature documenting the psychological and physical harms of solitary confinement has continued to grow, if anything, greatly accelerating in the number and scope of publications. To accurately reflect this fact, I have prepared a "White Paper," that briefly

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[16] C. Haney & M. Lynch, Regulating Prisons of the Future: The Psychological Consequences of Solitary and Supermax Confinement, 23 New York University Review of Law and Social Change 477-570 (1997).

[17] Haney (2003), supra note 14.

[18] C. Haney, Restricting the Use of Solitary Confinement, 1 Annual Review of Criminology 285-310 (2018).

summarizes the scientific and related research and writing documenting the harmful effects of solitary confinement in just the most recent four-year period, from 2018 (the date of my last published review) to 2022. That White Paper contains brief summaries of some 65 publications that address the harmfulness of solitary confinement, published just within this four-year period, and is attached as a Supplement to this written testimony.

A Culture of Harm

Most of the analyses of the harmfulness of solitary confinement are directed at the extreme levels of material deprivation, the lack of activity and other forms of sensory stimulation, and, especially, the absence of normal or meaningful social contact that prisoners experience and suffer from in these settings. This emphasis is not misplaced. There is no widely accepted psychological theory, correctional rationale, or conception of human nature of which I am aware to suggest that exposure to these powerful and painful stressors is neutral or benign and does not carry a significant risk of harm.

To be sure, the extreme deprivation, the isolating architecture, the technology of control, and the rituals of degradation and subjugation that exist in solitary confinement units are inimical to the mental health of prisoners. However, it would be naïve to assume that the nature of these environments does not also affect the staff who work inside.[19] In many such places, thinly veiled hostility, tension, and simmering conflict are often palpable. The interpersonal toxicity that is created in these environments can engender mistreatment and even brutality. What might be termed an "ecology of cruelty" is created in many

[19] C. Haney, A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons, 35 Criminal Justice and Behavior 956-984 (2008);

such places where, at almost every turn, guards are implicitly encouraged to respond and react to prisoners in essentially negative ways—through punishment, opposition, force, and repression.

For many correctional officers, at least initially, this approach to institutional control is employed neutrally and even-handedly—without animus and in response to actual or perceived threats. However, when punishment and suppression continue—largely because of the absence of any available and sanctioned alternative approaches—they become functionally autonomous and often disproportionate in nature. Especially when the use of these techniques persists in spite of the visible pain and suffering they bring about, it represents a form of cruelty (notwithstanding the possible lack of cruel intentions on the part of many of those who employ the harsh techniques themselves).

Unfortunately, the culture of harm that is created in many of these units also affects service providers, including those who are supposed to address the mental health needs of prisoners. Despite the large concentration of mentally ill prisoners in solitary confinement, the quality of mental health care in these units is sometimes much worse than elsewhere in the prison system. Some of this is due to limited resources; some prisons simply do not have the personnel to provide the kind of care that solitary confinement prisoners need. Some of it stems from built-in practical limitations. That is, solitary confinement units are located in separate, distant areas of the prison, access to the units themselves is difficult, and the procedures whereby prisoners are transported from their cells are cumbersome. But some of the poor quality care in certain units derives from the culture of harm to which I referred and the ease with which it is possible to simply "get used to" practices and procedures that would be seen as unacceptably compromised and inadequate in any other setting. For example, in many solitary confinement units it is not uncommon for mental health services to be delivered

in "treatment cages" (or what prisoners sometimes refer to as "shark cages" because of their resemblance to those underwater contraptions)—telephone-booth sized metal cages in which prisoners are confined during their "therapeutic hour."

Public Safety Concerns

A critically important but widely overlooked aspect of solitary confinement in the United States is the potential threat it represents to public safety. Solitary confinement not only subjects prisoners to the kind of psychologically damaging experiences I have described above but also does so without providing them with any opportunities to obtain meaningful programming or rehabilitative services. As a result, many prisoners are significantly handicapped when they attempt to make their eventual transition from prison back into the free world.

Indeed, an extensive amount of empirical evidence now establishes that time spent in solitary confinement not only has no demonstrable effect in reducing in-prison or post-prison violence, but also data to indicate that the experience of solitary confinement actually contributes to elevated rates of recidivism.[20] The explanation for this troubling fact is not difficult to discern.

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[20] The available research points to the *in*effectiveness of solitary confinement/restrictive housing in reducing in-prison infractions at an individual or systemic level, or that it reduces post-prison illegal behavior. Studies consistently show that solitary confinement either has no effect on future problematic prisoner behavior or, actually, may be counterproductive (i.e., increase subsequent problematic behavior). For example, *see:* C. Briggs, J. Sundt, & T. Castellano, The Effect of Supermax Security Prisons on Aggregate Levels of Institutional Violence. Criminology, 41, 1341–76 (2003) (no evidence that solitary confinement consistently reduced systemwide violence against staff or other prisoners); M. Colvin, The Penitentiary in Crisis: From Accommodation to Riot in New Mexico. Albany, NY: State University of New York Press (1992) (the increased use of solitary confinement was counterproductive in the attempt to reduce prison tensions); Lovell, D., Johnson, L., & Cain, K., Recidivism of Supermax Prisoners in Washington State, 53 Crime & Delinquency 633-656 (2007) ("[s]upermax prisoners committed new felonies at a [nonsignificantly] higher rate than nonsupermax controls" and "[p]risoners released directly from supermax to the community... showed significantly higher felony recidivism rates than their nonsupermax controls"); D. Mears & W. Bales, Supermax Incarceration and Recidivism, 47

Without oversimplifying, one of the things we have learned about how prisoners make successful transitions back into their communities of origin is that positive re-entry depends on their ability to connect to a supportive, caring group of other people, and the ability and opportunity to become gainfully employed. Solitary confinement significantly impedes both things. Prisoners' social skills atrophy severely under their starkly deprived and isolated conditions of confinement. The absence of any meaningful activity (let alone rehabilitative programming) in solitary confinement means that their often already limited educational and employment skills will have further deteriorated by the time they are released. Many prisoners come out of these units damaged and functionally disabled, and some are understandably enraged by the ways in which they have been mistreated. Crime—sometimes violent crime—is one predictable result. Moreover, very few solitary confinement units operate "step down" or

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Criminology 1131 (2009) ("we find evidence that supermax incarceration may increase violent recidivism"); R. Morris, Exploring the Effect of Exposure to Short-Term Solitary Confinement among Violent Prison inmates. Journal of Quantitative Criminology, 32, 1–22 (2016) ("[E]xposure to short-term solitary confinement... does not appear to play a role in increasing or decreasing the probability, timing, or development [of] future misconduct."); H. Butler, B. Steiner, M. Makarios, & L. Travis, Assessing the Effects of Exposure to Supermax Confinement on Offender Postrelease Behaviors, 97(3) The Prison Journal 275-295 (2017) ("no evidence that exposure to supermax confinement affected offenders' odds of recidivism or any other post-release outcomes"); J. Lucas & M. Jones, An Analysis of the Deterrent Effects of Disciplinary Segregation on Institutional Rule Violation Rates, Criminal Justice Policy Review, 30, 765–87 (2017). ("The findings indicate... that the experience of disciplinary segregation does not reduce subsequent inmate misconduct and therefore suggest that it may not be an effective institutional practice."); J. Medrano, T. Ozkan, & R. Morris, Solitary Confinement Exposure and Capital Inmate Misconduct, American Journal of Criminal Justice, (2017) ("The main finding of the current research is that SC is no deterrent on inmate misconduct. There is good reason to suspect that it makes the situation worse..."); K. Reiter, K., Parole, Snitch, or Die: California's Supermax Prisons and Prisoners, 1997-2007. Punishment & Society, 14, 530-563 (2012) (finding no evidence that the use of solitary confinement reduced the influence of gangs in the California prison system); S. Shalev, S., Supermax: Controlling Risk through Solitary Confinement. Cullompton, UK: Willan Publishing (2009) (acknowledging that "studies suggest that solitary confinement is not an effective tool for managing those defined as 'problem' or 'difficult' prisoners and may even be counterproductive," including with respect to gang members). In addition, for more recent research that corroborates the fact that there is a lack of deterrent effect—and may well be a paradoxical criminalizing effect—achieved by solitary confinement/restrictive housing, *see* the numbered paragraphs 55–64 in the White Paper attached as a Supplement to this written testimony, which provides summaries of these recent articles.

transitional programs that assist prisoners in negotiating the steep barrier from isolation to the intensely social world outside of prison.

In some instances, the failures that solitary confinement prisoners experience when they try to make this nearly impossible transition on their own are tragic, not just for themselves but for others who may become the innocent victims of their desperate plight. For example, some years ago I encountered one California prisoner who had been convicted of non-violent drug offenses, and entered the prison system with no pre-existing symptoms of mental illness. Yet, when I saw him he was lying catatonic, unresponsive, and incoherent on the floor of his isolation cell in a California SHU unit. He was eventually diagnosed as schizophrenic, but was retained in the same unit where his mental illness had originated. The next time I encountered him was several years later, after he had been released from prison. He was on trial for capital murder, an offense that had been committed just months after being taken directly from his isolation cell, placed on a bus and eventually onto the streets of a California city, with no pre-release counseling or transitional housing of any kind. I wish that I could say that this tragic and extreme outcome was the only one of its kind that I have personally encountered, but it certainly is not.

Proposed Remedies

Solitary confinement continues to be used on a widespread basis in the United States despite empirical evidence suggesting that its existence has done little or nothing to reduce system-wide prison disorder or disciplinary infractions.[21] In fact, at least one prison system that drastically reduced the

[21] Briggs, C., Sundt, J., & Castellano, T., The effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence, 41 Criminology 1341-1376 (2003).

number of prisoners whom it housed in solitary confinement by transferring them to mainline prisons experienced an overall reduction in misconduct and violence system-wide.[22] As prison populations continue to gradually decline, and the nation's correctional system rededicates itself to program-oriented approaches designed to produce positive prisoner change, the resources expended on long-term solitary confinement should be redirected to a more cost-effective and productive strategy of prison management.

Several years ago, after it had conducted a number of public hearings in locations around the country, the bipartisan Commission on Safety and Abuse in America's Prisons, chaired by former Attorney General Nicholas Katzenbach, called supermax prisons "expensive and soul destroying"[23] and recommended that prison systems "end conditions of isolation."[24] Short of that, in my opinion, there are some things that can and should be implemented on a nationwide basis. Solitary confinement continues to be structured and operated in ways that are designed to deprive, diminish, and punish. With that in mind, steps need to be taken to entirely exclude the most vulnerable prisoners from exposure to these conditions,[25] to use solitary confinement as rarely as possible and only as an

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[22] See T. Kupers, T. Dronet et al, Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs, 36 Criminal Justice and Behavior 1037-1050 (2009).

[23] Gibbons, J., & Katzenbach, N. (2006). Confronting Confinement: A Report of the Commission on Safety and Abuse in America's Prisons. New York: Vera Institute of Justice, at p. 59.

[24] Id. at 57.

[25] Persons under the age of 18 and those who suffer from serious mental illness are singularly unsuited for long-term solitary confinement and they should be absolutely excluded from being housed there. In fact, persons with serious mental illnesses are categorically excluded from solitary confinement in a number of states (e.g., California, Wisconsin, Ohio), but not all. Moreover, the ABA Standards on the Treatment of Prisoners (at section 23-2.8(a)) require this. See: http://www.americanbar.org/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners.html#23-2.7

absolute last resort, to impose significant and enforceable limits on the time that any prisoners are housed there, to be measured in days rather than weeks, months or years,[26] provide all prisoners with meaningful steps or pathways that they can pursue to accelerate their release from solitary,[27] significantly change the nature of the isolation units themselves to mitigate the damage that they inflict, and provide prisoners who are being released into mainline prison populations or into free world communities with effective transitional services to ensure their post-solitary success and reduce the risk of harm to others once they are released.

The grave psychological risks posed by solitary confinement make the overall mental health recommendations urgently important. Prisoners must be systematically screened for mental illness as they come into solitary confinement units, and continuously monitored for signs of developing mental illness or serious mental distress. Those whose problems may fall below the standard required for exclusion and who therefore remain in solitary confinement must be given access to enhanced (rather than substandard) mental health resources. Finally, all isolated prisoners must be provided with transitional or "step down" services and programs that are explicitly designed to meaningfully focus on and

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[26] For example, Rule 44 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules") defines solitary confinement as: "the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days." UNITED NATIONS OFFICE ON DRUGS & CRIME, THE UNITED NATIONS STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS (THE NELSON MANDELA RULES) 14 (2015) https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf [https://perma.cc/62U6-Q4SJ].

[27] For example, see the general discussion in: C. Haney, The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment, at pp. 33-66. *See, also*, Joan Petersilia, When Prisoners Come Home: Parole and Prisoner Reentry. New York: Oxford University Press (2003).

address the psychological changes that they are likely to have undergone in the course of their solitary confinement.

In fact, in 2020, my colleagues and I published a "Consensus Statement" that was developed in an International Summit on Solitary Confinement and Health held in 2018 that synthesized existing the then-current scientific, correctional, and human rights status of solitary confinement, and articulated a set of policy recommendations and ethical principles that the expert attendees agreed should govern the use of the practice. A copy of that set of guiding principles is also attached as Supplement 2 to this written testimony.

Thank you for the opportunity to participate in this important legislative hearing and to help your Committee address this very significant issue. I am hopeful that it will assist you in your consideration of possible legislative oversight and reform in Pennsylvania.

White Paper Summarizing the 2018-2022 Publications That Address the Harmfulness of Solitary Confinement and Social Isolation[1]

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As several recent collaborations between the nation's top correctional leaders and legal scholars at the Yale Law School (in the form of CLA/Liman reports) have acknowledged,[2] along with numerous respected experts, there is now widespread agreement in the scientific community, numerous professional mental health, human rights, and legal organizations, and even many correctional officials that solitary confinement produces a wide range of harmful effects. Despite this overwhelming consensus, an occasional commentator characterizes the broad and long-standing empirical record on the harmfulness of solitary confinement as "mixed," or "inconsistent." Most often, this view is based largely on a single publication, O'Keefe et al. (2012),[3] which is not only now more than a decade old

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[2]Association of State Correctional Administrators& Liman Center for Public Interest Law, REFORMING RESTRICTIVE HOUSING: THE 2018 ASCA-LIMAN NATIONWIDE SURVEY OF TIME-IN-CELL (October, 2018); Correctional Leaders Association & Arthur Liman Association, TIME-IN-CELL 2019: A SNAPSHOT OF RESTRICTIVE HOUSING, BASED ON A NATIONWIDE SURVEY OF U.S. PRISON SYSTEMS. (September, 2020).

[3] For a lengthy discussion of the methodological flaws and a discussion of why and how they render the O'Keefe et al. results not only flawed but uninterpretable, see Craig Haney, *The Psychological Effects of Solitary Confinement: A Systematic Critique*, 47 CRIME & JUST 365 (2018) and, among many others, David Lovell and Hans Toch, who called its findings

but also was widely criticized almost from the moment it first appeared. In any event, continued reliance on a single, flawed, and now dated publication reflects a lack of appreciation for the sheer amount of research and writing that has been—and continues to be—done on solitary confinement that clearly and consistently documents the significant damage that it can inflict.

In this White Paper, in order to underscore the sheer size and consistency of the empirical record that has been amassed on the harmful effects of solitary confinement, I summarize only the most recent empirical studies, literature reviews, and other scholarly publications—specifically, those that have appeared in just the last four years, between 2018 and 2022. The results and conclusions of this extensive body of research and writing are robust, having been produced by scholars and researchers from a range of different disciplinary backgrounds, who approached the topic from different intellectual perspectives and employed a variety of research methods. The consistency of their findings and conclusions further corroborates, deepens, or extends our knowledge of the significant risk of harm to which prisoners in solitary confinement are exposed, and/or explicitly

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"flabbergasting" and impossible to interpret. David Lovell & Hans Toch, *Some Observations about the Colorado Segregation Study*, 13(1) CORR. MENT. HEALTH R. 3–4, 14 (2011).

acknowledges the broad, long-standing scientific consensus about the harmfulness of the practice.

Of course, these more recent publications on the harmful effects of solitary confinement are in addition to the substantial historical evidence that led the nation to abandon its routine use of the practice in the 19th century, and the substantial body of research and scholarly writing generated in the period that preceded the 2018 date at which this White Paper discussion commences. The 65 publications discussed below include comprehensive literature reviews, newly collected original empirical data, analyses of the causes of negative outcomes (such as suicide) that include the role of solitary confinement, and authoritative commentaries by experts or expert groups.[4] All but one reach essentially the same conclusion—solitary confinement has harmful effects on the psychological and/or physical well-being of persons exposed to it. [The numbered paragraphs below correspond to each publication reviewed.]

1. For example, in 2018 Alicia Piper and David Berle reviewed research that examined the relationship between forms of trauma experienced during incarceration and post-traumatic stress disorder ("PTSD") symptoms, and

[4] I concede that, although this is intended as a reasonably comprehensive list of all of the articles published during this time frame, it may not be entirely exhaustive. The topic is now so widely and diversely studied, that I cannot guarantee that even a conscientious search has uncovered literally all of the relevant publications. This, too, speaks to the breadth of the scientific consensus that has been established on the harmfulness of solitary confinement.

identified the significant empirical association between PTSD and the experience of having been in solitary confinement.[5] They concluded that this particular outcome "supports earlier research, suggesting that solitary confinement represents an environment of physical and psychological deprivation, and may also represent a barrier to treatment and other opportunities of growth."[6] As the authors summarized: "[T]hese results highlight the detrimental effects of solitary confinement on the psychological well-being of incarcerated individuals."[7]

2. Also in 2018, Carly Chadick and her colleagues reported on a study conducted in a Kansas prison, comparing prisoners who had spent on average nearly two years in solitary confinement with a matched sample of general population prisoners.[8] Despite using a convenience measure that had been administered to all prisoners entering the Kansas Department of Corrections that was not intended as, nor necessarily a very sensitive measure of, psychological distress, Chadick et al. nonetheless found that the prisoners in solitary confinement

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[5] Alicia Piper & David Berle, *The Association between Trauma Experienced during Incarceration and PTSD Outcomes: A Systematic Review and Meta-Analysis*, 30 J. FORENSIC PSYCHIATRY & PSYCHOL. 854-875 (2018), at 866.

[6] *Id.* at 868.

[7] *Id.*

[8] Carly Chadick, Ashley Batastini, Samuel Levulis, & Robert Morgan, *The Psychological Impact of Solitary: A Longitudinal Comparison of General Population and Long-Term Administratively Segregated Male Inmates*, 23 LEGAL & CRIMINOL. PSYCHOL. 101-116 (2018).

not only showed "notable" increases in scores for anxiety and PTSD after spending time in solitary but also that they "endorsed greater post-assessment levels of anxiety, depressed mood, post-traumatic stress, and somatoform complaints compared to non-segregated inmates."[9] Not surprisingly, Chadick et al. did not find that significant negative changes occurred on literally every measured dimension of harm (a fact that, for some reason, they chose to emphasize), but their data did show that prisoners in solitary confinement had elevated pre- and post-scores on literally 9 of the 10 scales that were administered.[10] Chadick et al. concluded their article with a series of recommendations about prison "best practices" with respect to solitary confinement, citing to an article I co-authored that proposed significantly reducing its use in light of the harmful consequences of isolation.[11] If

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[9] *Id.* at 110. The fact that "neither the segregated nor non-segregated inmates endorsed symptoms that were in the clinically significant range" despite the fact that 62.9% of both groups had a formal mental health diagnosis may underscore the insensitivity of the measure. *Id.* at 104, 110.

[10] *Id. at* 108, Table 2 (comparing Administrative Segregation prisoners for Pre- and Post-scores). It is interesting to note that, in the original sole authored report from which the later co-authored publication's data were taken, Carly Chadick wrote that "[p]articipants in segregation scored higher on the anxiety, major depression, and delusional disorder scales than those who never spent time in segregation, coinciding with previous research," and ended by encouraging mental health workers to "help prevent psychological deterioration from occurring" in solitary confinement. *See* Carly Chadick, *Psychological Symptoms of Administrative Long-Term Segregation: A Pre- and Post-Segregation Analysis at a Kansas Correctional Facility*, Master's Thesis, Emporia State University (2009) at 26, 30-31.

[11] Cyrus Ahalt, Craig Haney, Sarah Rios, Matthew Fox, David Farabee, & Brie Williams, *Reducing the Use and Impact of Solitary Confinement in Corrections,* 13 INT'L J. PRISONER HEALTH 41-48 (2017).

conscientiously implemented, Chadick et al.'s recommendations—which included prohibiting the isolation of mentally ill prisoners except in "extreme instances" of "imminent danger," instituting "therapeutic stepdown" programs for prisoners who have served more than 60 days in solitary confinement, providing for enhanced mental health monitoring and the removal of prisoners who display symptoms of decompensation, directly involving mental health personnel in determining disciplinary sanctions, and creating clear behavioral markers to enable prisoners to obtain their release from solitary—would result in very significant reductions in the use of solitary confinement overall and help to ameliorate at least some of its well-known psychological harms.

3. A 2018 literature review by Hunter Astor, Thomas Fagan, and David Shapiro focused on studies published before then, ones they described as "peer-reviewed, empirical studies supported by quantitative data" (although curiously omitting my own 2003 study, despite the fact that it met those criteria).[12] They concluded that the task of comparing studies was compromised by variations in solitary confinement practices and a lack of standardization in research protocols and that, overall, the results were "mixed," including that "[n]umerous cross sectional studies report a relatively high prevalence of psychological

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[12] Hunter Astor, Thomas Fagan, & David Shapiro, *The Effects of Restrictive Housing on the Psychological Functioning of Inmates*, 24 J. CORRECTIONAL HEALTH CARE 8-20 (2018).

symptoms/psychopathology… and suicide attempts/hospitalizations," as did "studies using at least one comparison sample" (but noting that both kinds of studies were limited by the possible influence of pre-existing conditions),[13] and that longitudinal studies suggested "positive, neutral, or adverse effects of restrictive housing on psychological functioning" (findings that could also be limited by, among other things, "high rates of attrition" which, they correctly noted, was "relatively common for studies conducted in correctional settings").[14]

4. In the next year, 2019, Keramit Reiter and her colleagues published the results of their research on the effects of long-term solitary confinement in several different Washington State prisons. Focusing on a sample of more than one hundred prisoners, who were housed on average for 14.5 months in several different Washington State prisons,[15] they used a psychiatric rating scale, qualitative interviews, and medical file reviews to assess distress and harm. The

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[13] *Id.* at 9-10.

[14] *Id.* at 16. It is worth noting that, in addition to omitting my 2003 publication, Astor et al. did not take into account the numerous additional publications that became available during or after 2018, beyond the time their literature review was written and published. Those studies, reviewed here, were omitted from the Astor et al. review, yet all corroborated the already substantial evidence of harmfulness. It is entirely reasonable to speculate that, in light of this substantial additional scientific evidence, little or none of which was "mixed," Astor et al. might have a different conclusion.

[15] Keramit Reiter, Joseph Ventura, David Lovell, Dallas Augustine, et al., *Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017-2018*, 110 AM. J. PUB. HEALTH S56-S62 (2019).

researchers reported that "clinically significant" psychiatric ratings were found in "as much as a quarter of the population sampled, especially for the depression and anxiety symptoms," and that there was "additional evidence of clinically significant psychiatric distress in as much as half of the population sampled."[16] Moreover, the interview data collected from the prisoners housed in solitary confinement provided additional self-reported evidence of the "emotional toll" of being in solitary confinement and the feelings of social isolation that it engendered.[17] Not only were "[s]ymptoms such as anxiety and depression [...] especially prevalent" among the isolated prisoners but so, too, were "symptoms ostensibly specific to solitary confinement, such as sensory oversensitivity and a perceived loss of identity..."[18] The authors concluded that the association of solitary confinement with psychopathology calls into question the usefulness of the practice, "let alone its justice."[19]

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[16] *Id.* at S58. These researchers also observed that, although the Brief Psychiatric Rating Scale they employed is widely used to identify psychiatric symptoms, it "does not capture the full spectrum of psychiatric distress incarcerated people experience in solitary confinement," so that, "[i]f we study people in solitary confinement solely with instruments validated with non-incarcerated populations... we may fail to capture the extent of incarcerated people's psychological distress." *Id.* at S60-61.

[17] *Id.* at S59.

[18] *Id.* at S60.

[19] *Id.* at S61.

5. Also in 2019, Michael Campagna and his colleagues conducted a study with a sample of over 400 prisoners from a prison system in the Western United States.[20] Although—at least compared to some studies—the amount of time prisoners spent in solitary confinement was relatively modest (averaging 21.15 days), even when researchers controlled for a host of other variables, the number of days a person spent in solitary confinement "was negatively and significantly associated with mental health status."[21] Time spent in solitary confinement not only negatively affected mental health status, as indicated by scores on a mental health needs assessment, but had other deleterious effects as well. Thus, the researchers also found that time spent in solitary confinement had presumably unintended negative consequences—it significantly negatively affected the prisoners' behavior toward authority figures—and failed to achieve several

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[20] Michael Campagna, et al., *Understanding Offender Needs Over Forms of Isolation Using a Repeated Measures Design*, 99 PRISON J. 639-661 (2019).

[21] *Id.* at 649 (emphasis added). They found that other background variables also were negatively associated with mental health. However, even after those variables were controlled for, days spent in solitary confinement had an adverse effect on mental health. Campagna et al. acknowledged that although "the results support the hypothesis that [solitary confinement] has a negative effect on offenders' mental health," *id.* at 650, and the measured negative effects on mental health were significant (such that each day in solitary confinement decreased the odds of a positive mental health score by 1.7%), the adverse effects were not as drastic or deleterious as those reported in some other research. This is not surprising, given the fact that the conditions of confinement in other studies were often identified as very severe (for example, "supermax"-type conditions, as opposed to the unspecified conditions of solitary confinement in Campagna et al.'s study), and the amounts of time spent in solitary confinement in those other studies were measured in months or years, rather than weeks or days, as in the study Campagna and colleagues conducted. *Id.* at 649, 652.

apparent goals (i.e., it did not have any positive effect on impulse control or on a measure of what the researchers termed the prisoners' "readiness to change").[22] In light of their findings, the authors joined prior recommendations that prison administrators should "[i]nevitably" develop alternative approaches to managing prisoner behavior "that minimize the use of isolation" and should prohibit it outright for prisoners with mental health problems "except in the case of extreme circumstances related to safety [...]"[23]

6. Another study, published in 2019, examined a different issue—the association of self-reported time spent in solitary confinement with mental illness diagnoses, in this instance among juveniles waived into the adult criminal justice system.[24] Based on a sample of 92 juveniles who had spent time in adult criminal justice facilities in New Jersey, Colby Valentine and her colleagues reported that those "who spend more time in segregation have a greater number of mental health diagnoses."[25] Even when a host of other variables (e.g., demographics, waived offense, medication use, physical and sexual abuse while incarcerated) were taken

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[22] *Id.* at 650-651.

[23] *Id.* at 652.

[24] Colby Valentine, Emily Restivo, & Kathy Wright, *Prolonged Isolation as a Predictor of Mental Health for Waived Juveniles*, 58 J. OFFENDER REHABILITATION 352-369 (2019).

[25] *Id.* at 360.

into account, the researchers found that "the number of mental illness diagnoses for waived youth increases by approximately 26% with every one-unit increase in time in segregation."[26] They concluded that, given the "limited social contact with other human beings," and the "limited and inadequate access to medical and mental health treatment as well as to rehabilitative and educational programming" that often characterizes solitary confinement units, "it is not surprising that segregation may be psychologically damaging, especially for juveniles."[27]

7. My own research, published in a journal article in 2018 and a 2020 book chapter, reported on the results of a study that used a different methodology, contrasting the psychological state of a group of extremely long-term solitary confinement prisoners with a comparable sample of prisoners currently housed in general population.[28] The prisoners in both groups were randomly selected to ensure representativeness (but explicitly did not include anyone on the prison's mental health caseload).[29] I found that those prisoners who were subjected to

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[26] *Id.* at 362.

[27] *Id.* at 363.

[28] *See* Haney, Restricting Solitary Confinement (2018), *supra* note **Error! Bookmark not defined.**, and Craig Haney, *Solitary Confinement, Loneliness, and Psychological Harm*, in Jules Lobel & Peter Scharff Smith (Eds.), SOLITARY CONFINEMENT: EFFECTS, PRACTICES, AND PATHWAYS TO REFORM (pp. 129-152). New York: Oxford University Press. The solitary confinement prisoners had spent 10 continuous years or more housed in the Security Housing Unit at Pelican Bay State Prison; the general population prisoners had been incarcerated for at least 10 continuous years and were now housed in the mainline unit at the same prison.

extremely long-term, continuous solitary confinement reported nearly twice the number of symptoms of stress-related trauma and twice the number of isolation-related pathology overall, as compared to the prisoners in prison for comparable amounts of time but who were currently housed in general population. In addition, the isolated prisoners reported more than twice the mean intensity levels for both categories of problematic symptoms than the long-term general population prisoners.[30]

8. In a related book chapter of mine, I analyzed and discussed a different aspect of the Pelican Bay data, namely the extent to which persons housed in extremely long-term segregation suffered very severe forms of loneliness. In fact, compared to long-term prisoners who were currently housed in general population, the extremely long-term isolated prisoners were significantly more "lonely," as measured by a standard and widely used loneliness scale. Indeed fact, they

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[29] In *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995), the Court prohibited the housing of mentally ill prisoners in the Pelican Bay solitary confinement unit. To ensure the comparability of the samples in this regard, no general population prisoner who was on the prison system's mental health caseload was included in the study.

[30] A sequential multiple linear regression was used to determine whether solitary status explained the difference in the intensity of these isolation-related pathological symptoms. In fact, being in solitary confinement was by far the largest contributor to the intensity of isolation-related symptoms suffered, even after controlling for age, marital status, and estimated total time in prison.

reported extraordinarily high levels of extreme loneliness rarely found anywhere in the literature.[31]

9. In more general research that focused on "how particular prison characteristics are associated with mental health difficulties,"[32] Timothy Edgemon and Jody Clay-Warner 2019 article noted that "institutional characteristics have unique associations with inmate mental health beyond individual-level risk factors."[33] Their study of a national sample of over 5,000 men incarcerated in over 200 different prisons across the country found that the more punitive and depriving the prison environment (i.e., higher security level prisons, fewer work assignments and visits, prohibiting television access, higher numbers of disciplinary infractions imposed), the greater the amount of measured depression that existed among the prisoners. An almost identical pattern of results was found for measured levels of hostility. In addition, and more directly relevant to the issues at hand, they found that "[i]nmates who were placed in solitary isolation displayed higher levels of depression than inmates who were not"[34] and, similarly, those housed in solitary

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[31] *See* Dan Russell, Letitia Peplau, & Carolyn Cutrona, *The Revised UCLA Loneliness Scale: Concurrent and Discriminant Validity Evidence*, 39 J. PERSONALITY & SOC. PSYCHOL. 472-480 (1980).

[32] Timothy Edgemon & Jody Clay-Warner, *Inmate Mental Health and the Pains of Imprisonment*, 9(1) SOCIETY MEN. HEALTH 33-50 (2019), at p. 34.

[33] *Id.* at 35.

[34] *Id.* at 42.

"showed higher levels of hostility than inmates who were not."[35] Among the overall policy implications that Edgemon and Clay-Warner drew from their study was "the need to create correctional institutions that are less psychologically damaging," and "reducing punitiveness in prison sanctioning."[36]

10. To my knowledge, virtually every study of the topic has found that suicide and rates of self-harm are significantly higher in solitary confinement than in other prison settings.[37] Several publications that appeared during the period covered by my review underscore the heightened risk of self-harm and suicidality that solitary confinement incurs. For example, in 2018 Robert Canning and Joel Dvoskin acknowledged that suicide was related to placement in solitary confinement and that even prisoners who were placed there for their own

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[35] *Id.* at 43.

[36] *Id.* at 45.

[37] For examples of pre-2018 research and writing that acknowledged the relationship between solitary confinement and suicidality, see: Meredith Dye, *Deprivation, Importation, and Prison Suicide: Combined Effects of Institutional Conditions and Inmate Composition*, 38 J. CRIM. JUST. 796-806 (2010); Seena Fazel, Julia Cartwright, Arabella Norman-Nott, & Keith Hawton, *Suicide in Prisoners: A Systematic Review of Prisoners*, 69 J. CLINICAL PSYCHIATRY, 1721-1731 (2008); Stefan Fruehwald, Teresa Matschnig, Franz Koenig, Peter Bauer, & Patrick Frottier, *Suicide in Custody: Case-Control Study*, 185 BRIT. J. PSYCHIATRY 494-498 (2004); and Fatos Kaba, Andrea Lewis, Sarah Glowa-Kollisch, James Hadler, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442-447 (2014).

protection may experience "anxiety and agitation" that "can rise to psychotic proportions and quickly precipitate a suicidal crisis."[38]

11. Several years later, in 2022, Canning joined with another colleague, Alan Berman, to publish an article that began by noting that "[s]uicide is a leading cause of death in U.S. correctional populations."[39] Discussing the "proximal risks" for prison suicide and the "critical need" not only for research on the topic but also prevention strategies that went beyond relying on a person's history of prior attempts or currently expressed ideation, they repeated the conclusions of earlier analyses by Canning and Dvoskin to the effect that "being medically ill, having a history of childhood maltreatment, and placement in segregated housing" were additional, important risk factors.[40] In addition, however, Berman and Canning identified several "imminent and symptomatic risk factors" for suicide that are especially notable in the present context, precisely because they are among the known psychological reactions to being placed in solitary confinement, including "current anxiety/agitation," "sleep disturbance," social isolation/withdrawal,"

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[38] Robert Canning & Joel Dvoskin, *Preventing Suicide in Detention and Correctional Facilities*, in J. Wooldredge & P. Smith (Eds.), OXFORD HANDBOOK OF PRISONS AND IMPRISONMENT (pp. 551-578). New York: Oxford University Press (2018), at p. 555.

[39] Alan Berman, and Robert Canning, *Proximal Risk for Suicide in Correctional Settings: A Call for Priority Research*, 19(3) PSYCH. SERV. 407-412 (2022).

[40] *Id.* at 408.

"feelings of 'frantic hopelessness,'" affective disturbance," "irritability," "insomnia," and "nightmares."[41]

12. Relatedly, in 2019, Rafaella Calati and her colleagues published an extensive narrative review of the literature on "the link between social isolation… and suicidal thoughts and behaviors," considering the results of a wide range of studies on the topic.[42] Although the review itself considered "social isolation" in a wide range of different contexts (including but not limited to prisons), After reviewing numerous other systematic reviews, meta-analyses, and narrative reviews on the topic, as well as observational studies on large samples and some more limited qualitative studies, Calati et al. concluded that "[b]oth the objective condition of being alone (e.g., living alone) and the subjective feeling of being alone (i.e., loneliness) were strongly associated with suicidal outcomes."[43] The authors noted that "[t]he specific condition of physical and social isolation of life in prison intensifies suicidal risk," that "suicidal behaviors are frequent in this context," and that "being in isolation or segregation cells is a risk factor for

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[41] Id. at 410.

[42] Rafaella Calati, et al., *Suicidal Thoughts and Behaviors and Social Isolation: A Narrative Review of the Literature*, 245 J. AFFECTIVE DIS. 653-667 (2019), at p. 660.

[43] *Id.* at 663.

suicide, while contacts with family and inmates might represent a protective factor."[44]

13. Perhaps the most extensive analyses of the causes of prison suicide have been conducted by Louis Favril and his colleagues, including in a series of publications that appeared between 2019 and 2022. In the first, Favril, Ciska Wittouck, Kurt Audenaert, and Freya Vander Laenen noted that suicide is the "leading cause of mortality in custodial settings worldwide.[45] Examining 17 years of suicide data from the Belgium prison system between 2000 and 2016, they reported that 60% of all suicides occurred in single-occupant cells,[46] and characterized the fact that one in ten suicides occurred among prisoners housed in solitary confinement as "worrying at the least," largely because "the use of solitary confinement can be detrimental to prisoners' mental health and well-being."[47]

14. In the second Favril publication on the topic, this one appearing in 2020, he and his colleagues (Rongquin Yu, Keith Hawton, and Seena Fazel) systematically analyzed the relationship between solitary confinement and self-

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[44] *Id.* at 661.

[45] Louis Favril, Ciska Wittouck, Kurt Audenaert, & Freya Vander Laenen, *17-year National Study of Prison Suicides in Belgium* 40 CRISIS 42–53 (2019), at 42.

[46] *Id.* at 46.

[47] *Id.* at 48.

harm and suicide by conducting a meta-analysis of numerous previously published studies that had been done across a range of some 20 countries. They concluded that the "environmental risk factor" of solitary confinement was "clearly associated with self-harm."[48]

15. Favril's sole-authored, follow-up literature review, published the next year, in 2021, examined the epidemiology of and risk factors for prison suicide, and included a series of recommendations for prevention.[49] He noted that, in addition to a number of pre-existing risk factors (such as economic disenfranchisement and exposure to childhood adversity), "disconnection from family and friends on the outside" of prison is "a strong and consistent risk factor for suicidal thoughts and behaviour in prisoners," and also that "there is evidence that solitary confinement itself is an independent risk factor for suicidal behavior, even after release from prison."[50] With these independent risks in mind, Favril recommended that "[a]s a general principle, prisoners [at imminent risk of suicide] should be housed in the least restrictive accommodation which at the same time

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[48] Louis Favril, Rongqin Yu, Keith Hawton, & Seena Fazel, *Risk Factors for Self-Harm in Prison: A Systematic Review and Meta-Analysis*, 7 LANCET: PSYCHIATRY 682–691 (2020), at 688.

[49] Louis Favril, *Epidemiology, Risk Factors, and Prevention of Suicidal Thoughts and Behaviour in Prison: A Literature Review*, 61(1) PSYCHOLOGICA BELGICA, 341-355 (2021).

[50] *Id.* at 345.

maximizes their safety." Specifically, "[s]olitary confinement as a preventative measure should be avoided given its harmful potential." He noted further: "Whilst interventions aimed at the physical prevention of suicide may have the ability to save lives, they do not address the reasons why prisoners are suicidal in the first place, nor do they reduce the longer-term risk of suicide. Appropriate psychosocial care and support should be provided."[51]

16. Finally, in 2022, Favril and colleagues Jenny Shaw and Seena Fazel conducted an updated, comprehensive meta-analytic review whose findings were consistent with their earlier results, including the fact that, among a number of the "custodial factors" that they examined, solitary confinement was the one that was most significantly associated with in-prison suicide attempts.[52]

17. In addition to the extensive literature on the psychological harm that solitary confinement inflicts on inmates, there is extensive literature on the *physical* harm and injury prisoners suffer when subjected to long-term segregation. Thus, a number of studies done in the past few years have documented the range of negative physical or medical effects that persons suffer in solitary confinement. For example, in a 2019 study, Lauren Brinkley-Rubinstein and her colleagues

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[51] *Id.* at 348.

[52] Louis Favril, Jenny Shaw, & Seena Fazel, *Prevalence and Risk Factors for Suicide Attempts in Prison,* 97 CLIN. PSYCH. REV 102190 (2022).

showed that the stressfulness and long-term damage that is inflicted by solitary confinement can adversely affect someone's life expectancy. Specifically, they analyzed the experiences of more than 200,000 people who were released from a state prison system between 2000 and 2015 and found that those persons who spent any time in solitary-type confinement (such as administrative or disciplinary segregation) "were 24% more likely to die in the first year after release."[53] Prisoners who spent time in solitary-type confinement also were more likely to commit suicide (78% more likely than other inmates) and to be victims of homicide (54% more likely) after being released from prison,[54] and they were "127% more likely to die of an opioid overdose in the first 2 weeks after release."[55]

Several recent publications that address the harmfulness of social isolation *outside* the extreme case of solitary confinement nonetheless are directly related to the issues at hand. Although they are too numerous to review comprehensively, I discuss three examples of the many *neuroscientific* studies on social isolation that have been published over this period. I selected these three from many other possible publications because their authors explicitly connected their research to

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[53] Lauren Brinkley-Rubinstein et al., *Association of Restrictive Housing During Incarceration with Mortality After Release*, J. AM. MED. (October 4, 2019), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752350.

[54] *Id.*

[55] *Id.*

the experience of solitary confinement. These publications add two important dimensions to research and writing on the harmfulness of solitary confinement. The first is the way in which they help to buttress and corroborate the broader scientific framework within which the nature and source of the harmfulness of solitary confinement should be understood. That is, social isolation is a known toxin, something that is damaging to numerous other animal species, not just humans, establishing the generality of the findings. The second reason that these publications are important to acknowledge is that they underscore the overwhelming scientific consensus that social isolation and solitary confinement are, in fact, harmful. This fact is appreciated far beyond the boundaries of prison studies, including in disciplines such as neuroscience, where researchers are exploring the neurological nature of the harmfulness of isolation.

18. In the first of these, law professor Jules Lobel and neuroscientist Huda Akil reported on the well-documented neurological changes that take place in brain structure and function in response to social isolation and extrapolated them to the adverse effects of solitary confinement.[56] Summarizing the work and quoting the opinions of several prominent neuroscientists, including Akil herself as well as Matthew Lieberman, Naomi Eisenberger, and Michael Zigmond, they noted "it is

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[56] Jules Lobel & Huda Akil, *Law & Neuroscience: The Case of Solitary Confinement*, 147 DAEDALUS 61-75 (2018).

considered settled science within the field of psychology that humans and all mammals have a fundamental need for social connection," that the social pain of isolation involves "the same neural and neurochemical process invoked during physical pain," and that social isolation affects "neural activity in certain cortical regions of the brain associated with physical distress, in the same way physical pain would."[57] In addition, "neuroscience studies suggest that solitary confinement can 'fundamentally alter the structure of the human brain in profound and permanent ways,'" that "the key features of solitary confinement [are] 'sufficient to change the brain [...] dramatically depending on whether it lasts briefly or is extended,'"[58] and that the brains of isolated animals demonstrate impaired functioning and structural dimensions, including having fewer nerve cells, smaller neurons, and poorer neurotransmission.[59] Lobel and Akil concluded by suggesting that this evidence indicates that "neuroscience can play an important role in the legal struggle against prolonged solitary confinement.[60] Lobel and Akil also wisely noted something that I stated earlier about the practical and other obstacles that preclude conducting a "perfect" study of the effects of solitary confinement: "Not

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[57] *Id.* at 69 (quoting neuroscientist Matthew Lieberman).

[58] *Id.* at 69-70 (quoting neuroscientist Huda Akil).

[59] *Id.* at 70 (summarizing the work of neuroscientist Michael Zigmond).

[60] *Id.* at 71.

only would the cost of doing such a study be massive and untenable for a public interest lawsuit, but even if the necessary funds could be raised, prison officials do not allow scientists into the prison to do studies, and, absent an unlikely court order, the plan would not be workable."[61]

19. In the second recent publication that addressed the neurological effects of isolation,[62] Nancy Padilla-Coreano, Kay Tye, and Moriel Zelikowsky noted in 2022 that "prolonged" or "chronic" social isolation," which they define as lasting longer than two weeks, "can produce widespread and detrimental effects on the brain and behaviour across various species, may result in dire evolutionary consequences, produces territorial behaviour, aggression and social avoidance, is considered torture, and has even been used as a model for psychosis."[63] Reporting that their own research had "recently implicated subcortical structures in the brain state produced by prolonged social isolation," they suggested that "[s]olitary confinement, the most extreme form of social deprivation, is linked to poor mental health outcomes, aggression and loss of emotional control."[64]

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[61] *Id.* at 68.

[62] Nancy Padilla-Coreano, Kay Tye, and Moriel Zelikowsky, *Dynamic Influences on the Neural Encoding of Social Valence,* NATURE REVIEWS: NEUROSCIENCE 1-16 (2022) https://doi.org/10.1038/s41583-022-00609-1

[63] *Id.* at p. 2 (internal references omitted).

[64] *Id.* at p. 10.

20. A final illustrative example of a neuroscientific discussion of the deleterious effects of social isolation on the brain is from a 2022 article by Jordan Grammer and Moriel Zelikowsky, in which they observed that "when humans or other animals are deprived of social contact for an extended period," the negative effects not only can affect quality of life but also "produce profound physiological and emotional deficits, which increase the risk for mortality, dementia, heart disease, stroke, and mental health disorders."[65] The authors went on to not that "[s]ocial isolation affects a wide range of social behaviors across species," including increased aggression, social withdrawal, negative perceptions of social situations, and reduced social aptitude."[66] Beyond these negative effects on humans, the authors also noted that "social isolation in a variety of animals has been shown to produce decreased social interaction, increased aggression, and disruptions in mating and courtship behavior."[67] Because of "the profound effect of isolation on multiple social behaviors," they call on researchers to further explore "the internal brain state produced by prolonged isolation."[68]

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[65] Jordan Grammer & Moriel Zelikowsky, *Neuroscience: The Sting of Social Isolation*, 32 CURRENT BIOLOGY R572-588 (2022), at R572 (internal references omitted). https://doi.org/10.1016/j.cub.2022.05.036

[66] Ibid.

[67] Ibid.

[68] Ibid.

21. In addition to studies of the adverse neurological consequences of social isolation, extensive research has examined its harmful effects on other psychological domains, including the relationship of social isolation to different forms of mental illness and suicidality (of obvious relevance to solitary confinement settings, given the high concentration of mentally ill prisoners housed there and, as I noted earlier, the comparatively higher rates of suicide in these units). For example, Lindsay Bornheimer and her colleagues conducted a study of the relationship of social isolation to psychosis and suicide in a nationwide sample of adult participants.[69] They began by acknowledging that "a considerable body of empirical evidence suggests that social isolation is strongly associated with earlier mortality rates, higher rates of depression, increased risk for suicide, and worse mental health outcomes or quality of life overall,"[70] and that it may "contribute to the development of psychotic symptoms by reducing the possibility of reality testing through social interactions."[71] The researchers found that "all social isolation variables" that they measured were "independently significantly

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[69] Lindsay Bornheimer, Juliann Li, Vialis Im, Madeline Taylor, & Joseph Himle, *The Role of Social Isolation in the Relationships Between Psychosis and Suicidal Ideation*, 48 CLIN. SOC. WORK J. 54-62 (2020).

[70] *Id.* at 54.

[71] *Id.* at 54-55.

associated with an increased likelihood for experiencing suicidal ideation," that social isolation partially mediated relationships between delusions and hallucinations, and that depression through social isolation… related to the greatest increase in the likelihood of experiencing suicidal ideation."[72] In light of these findings, the authors recommended that the treatment of mentally ill patients "should optimally include the strengthening of a client's social support network and bolstering social skills overall,"[73] as well as providing "access to environments in which positive interpersonal relationships can be built."[74] Of course, none of these things are possible in solitary confinement units.

22. In addition to Brinkley-Rubenstein et al.'s earlier cited research on the relationship of solitary confinement to mortality or life expectancy, two other recent publications also addressed the medical risks of solitary confinement. In one, published in 2019, medical school professor Brie Williams and her colleagues focused on the negative physical/medical effects of solitary confinement by using data on the differential rates of hypertension between general population and solitary confinement prisoners. Specifically, they estimated the toll that solitary confinement took on the loss of what they termed "quality-adjusted life years" and

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[72] *Id.* at 58.

[73] *Id.* at 58.

[74] *Id.* at 59.

the increased medical costs of treating additional isolation-related cases of hypertension.[75] Noting that "a wealth of research describes the impact of isolation on stress hormone dysfunction and adverse cardiovascular outcomes including hypertension and mortality,"[76] Williams et al. estimated an approximately 31% increase in the prevalence of hypertension brought about by being subjected to solitary confinement which, by their calculations, would conservatively result in a loss of 5673 quality-of-life years and $155 million in additional future healthcare costs. As they concluded, "[t]hese findings, coupled with the growing consensus that solitary confinement is counter-productive as a public safety measure, suggest an urgent need to dramatically reduce solitary confinement using alternative strategies that achieve safety without compromising health."[77]

23. In 2020, Williams and Cyrus Ahalt also published an important book chapter that considered the likely outcome if the practice of solitary confinement were to be subjected to the rigorous FDA approval process that any proposed medication or treatment regimen must undergo, which entails a scrupulous

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[75] Brie Williams, Amanda Li, Cyrus Ahalt, Pamela Coxson, James Kahn, & Kirsten Bibbins-Domingo, *The Cardiovascular Health Burdens of Solitary Confinement*, 34 J. GEN. INTERNAL MED. 1977-1980 (2019).

[76] *Id.* at 1977.

[77] *Id.* at 1979-1980.

evaluation of existing evidence of safety and effectiveness,[78] concluding it likely would fail definitively on both counts. Specifically, as they noted, the best available scientific evidence indicates that solitary confinement not only would be declared "unsafe for humans," but actually would be found too unsafe to even permit subsequent phases of testing (whereby its efficacy would be evaluated).[79] Indeed, as they concluded: "In the broader medical and public health research context, *any* treatment or intervention with the known risks and lack of demonstrable benefits associated with solitary confinement would be immediately removed from the market and all future research on it discontinued."[80]

24. Another paper published during this time frame that addressed the medical/physical risks of solitary confinement appeared in 2020 and examined the "physical health impacts" of solitary confinement.[81] Using surveys and interviews

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[78] Brie Williams & Cyrus Ahalt, *First Do No Harm: Applying the Harms-to-Benefit Patient Safety Framework to Solitary Confinement*, in Jules Lobel & Peter Scharff Smith (Eds.), SOLITARY CONFINEMENT: EFFECTS, PRACTICES, AND PATHWAYS TO REFORM (pp. 153–71). New York: Oxford University Press (2020). The Lobel and Scharff Smith volume contains a number of important, relevant chapters on the harmfulness of solitary confinement. I have discussed only two—this one and some of my own work published in the same volume (*see* ¶¶7-8 *supra*).

[79] *Id.* at 163.

[80] *Id.* at 165–66.

[81] Justin Strong, Keramit Reiter, Gabriela Gonzalez, Rebecca Tublitz, Dallas Augustine, et al., *The Body in Isolation: The Physical Health Impacts of Incarceration in Solitary Confinement*, 15 PLoS ONE 1-20 (2020) at e0238510.

with an overall sample of several hundred prisoners, reviews of their medical and mental health files, and institutional data, Justin Strong and his colleagues found that one in seven prisoners housed in solitary confinement reported "clinically significant" concerns over their bodily health, and that the concerns tended to persist if the persons remained in solitary confinement. The health concerns included "a range of physical ailments directly connected to the conditions of their confinement" (including "various deprivations of movement, provisions… and human contact"),[82] and solitary confinement policies and practices "exacerbated [the prisoners'] physical ailments, especially their chronic health problems."[83] The authors also noted that the widespread complaints that prisoners voiced about "musculoskeletal pain" included the fact that it was often "untreated" and yet serious enough to interfere "(physically and mentally) with even those few, limited activities available to them in solitary confinement."[84] Strong et al. noted that because persons in solitary confinement "are left with very few options to effectively manage persistent pain" it appears "to foster more maladaptive behavior, such as ruminations, stress, and despair."[85] They concluded that,

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[82] *Id.* at 9.

[83] *Id.* at 10.

[84] *Id.* at 12.

[85] Ibid.

although they could not definitively establish the prevalence of symptoms and mechanisms of suffering in the units under study, "evidence is clear that solitary confinement poses serious health risks," and that "[p]hysical suffering reveals itself to be a crucial dimension of experience in solitary confinement."[86]

25. In Ellie Brown's 2020 "systematic review" of the solitary confinement literature she synthesized past quantitative "meta-analytic" reviews with narrative accounts of a broader range of empirical studies, as well as separately examining the results of sixteen studies focusing on psychological effects.[87] Although she noted that some of the past research was of uneven quality, Brown nonetheless concluded that a majority of the individual studies "revealed a negative effect of segregation" and that the symptomatology identified in those studies "was broad ranging," including higher levels of psychological distress, psychiatric morbidity, self-harm and, in one instance, a significant association between the experience of solitary confinement and post-traumatic stress disorder.[88] She also acknowledged that, among the results of studies that lacked control groups, "[i]mportantly, negative psychological responses such as

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[86] *Id.* at 15.

[87] Ellie Brown, *A Systematic Review of the Effects of Prison Segregation*, 52 AGGRESSION & VIOLENT BEHAV. 101389 (2020).

[88] *Id.* at 10.

hallucinations, hyper-responsivity to stimuli, perceptual distortions, anxiety and psychotic disturbances were common" as were elevated "prevalence and disproportionality of events such as suicide and self- harm," and that these findings were corroborated by "a substantial number of other studies, which adopt different methodological designs…"[89]

26. Similarly, a meta-analysis performed by Mimosa Luigi and her colleagues that was published in 2020, and encompassed 13 separate studies comprising a total sample of 382,440 prisoners overall, concluded that "solitary is associated with the psychological deterioration of inmates."[90] Although the association between solitary confinement and increased mental health symptomatology was moderate overall, "[h]igher quality studies from the systematic review also showed [solitary confinement] was related to deleterious effects with regards to mood symptoms, PTSD-related outcomes, psychotic experiences, hostility, self-injurious behavior, and mortality.[91] The researchers also observed that the fact that mental health staff typically have only "obstructed

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[89] *Id.* at 12.

[90] Mimosa Luigi, Laura Dellazizzo, Charles-Edouard Giguere, Marie-Helene Goulet, & Alexandre Dumais, *Shedding Light on "the Hole": A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality in Correctional Settings*, 11 FRONTIERS IN PSYCHIATRY 840 1-1 (2020).

[91] *Id.* at 6. Unlike some other meta-analytic reviews, Luigi et al. were careful not to overweight the results of the methodologically flawed "Colorado Study."

access to inmates" in solitary confinement, and rely heavily on the administration of psychotropic medications and "short and infrequent cell-front visits" for treatment, tends to "make monitoring of psychological deterioration difficult and possibly under detected."[92] Moreover, Luigi et al. found that "the association between psychological deterioration and [solitary confinement] exposure grew even stronger when removing a sample entirely composed of inmates with prior mental illnesses," indicating that prisoners "with prior mental illness are not driving the entirety of the association between [solitary confinement] and psychological distress."[93]

27. Also in 2020, I published a literature review in the *Northwestern Law Review* that pertained in a different but related way to these issues—an analytic summary of the vast amount of scientific evidence that has established the negative psychological and physical effects of *social isolation, social exclusion, and loneliness*, its applicability to the practice of solitary confinement, and the way in which this broad literature expands the narrative about harmfulness of placing prisoners in isolation. As I said in the article, "knowledge about solitary

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[92] *Id.* at 8.

[93] Ibid. They wisely raised another issue that may result in underestimates of the full magnitude of the psychological distress experienced in solitary confinement, namely that "cross-sectional or retrospective designs, such as those used in most studies included, do not account for the loss of inmates so adversely affected by [solitary confinement] that they necessitate transfer out of this housing." *Id.* at 9.

confinement does not exist in an empirical or theoretical vacuum," but is instead an extension of "a wealth of scientific knowledge about the adverse consequences [of social isolation, loneliness, and social exclusion] as they occur in context and settings outside prison."[94] Indeed, this research has underscored the "destructive and even life-threatening consequences of isolation."[95] If anything, because of how completely, forcefully, and pejoratively it is employed there, "adverse effects of isolation in a *correctional* setting are likely to be far greater."[96]

28. In addition to the empirical studies of the direct negative effects of solitary confinement, and the literature reviews discussing the range of harms it incurs, several other studies published in recent years reported on associations between the experience of solitary confinement and post-imprisonment negative psychological and other problematic events. For example, Brian Hagan and his colleagues reported in 2018 that formerly incarcerated persons with a history of having been in solitary confinement were significantly more likely to report PTSD symptoms than those without solitary confinement,[97] and that this relationship

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[94] Craig Haney, *The Science of Solitary: Expanding the Harmfulness Narrative*, 115 NW. U. L. REV. 211-256 (2020), at 222.

[95] *Id.* at 235.

[96] Ibid.

[97] Brian Hagan, Emily Wang, Jenerius Aminawung, Carmen Albizu-Garcia, et al., *History of Solitary Confinement Is Associated with Post-Traumatic Stress Disorder Symptoms among Individuals Recently Released from Prison*, 95 J. URB. HEALTH 141-148 (2018).

remained significant even after screening out persons with prior PTSD diagnoses and prior mental health conditions (but not those with a history of chronic mental health conditions).[98]

29. In 2020, Arthur Ryan and Jordan DeVylder reported on research showing that "[p]reviously incarcerated individuals with psychotic symptoms were [...] approximately 50% more likely to report a history of solitary confinement that those without psychotic symptoms,"[99] leading the authors to recommend the development of alternative means for managing psychotic-illness-associated behavior among incarcerated individuals without resorting to punitive and potentially harmful practices, such as solitary confinement and excessive physical restraint.[100]

30. Also in 2020, Christopher Wildeman and Lars Andersen examined the long-term "re-entry" consequences of solitary confinement.[101] Noting that being

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[98] *Id.* at 145-146.

[99] Arthur Ryan and Jordan DeVylder, *Previously Incarcerated Individuals with Psychotic Symptoms Are More Likely to Report a History of Solitary Confinement*, 290 PSYCHIATRY RES. 113064 (2020), at 2.

[100] *Id.* at 3.

[101] Christopher Wildeman & Lars Andersen, *Long-term Consequences of Being Placed in Disciplinary Segregation* 58 CRIMINOLOGY 423-453 (2020). The authors focused specifically on what is called "disciplinary segregation" in Denmark—a form of solitary confinement in which prisoners spend 22-23 hours per day in a cell as punishment for disciplinary infractions, for terms that "cannot exceed 4 consecutive weeks for any offense." *Id.* at 427.

placed in solitary confinement "is considered one of the most devastating experiences a human can endure,"[102] they used a complex set of statistical analyses to reach what they characterized as "two straightforward conclusions," namely that prisoners placed in solitary confinement "experience a larger percent increase in the risk of recidivism, measured here as a new conviction" as compared to prisoners who were not placed in solitary confinement, and that the isolated prisoners also suffered "decreas[ed] labor force participation" (i.e., had a more difficult time obtaining post-prison employment).[103] The authors concluded by noting that the use of solitary confinement in this context not only has long-term consequences for the persons subjected to it but "may also be counterproductive as placing prisoners in restrictive housing… can significantly compromise their chance of successfully reintegrating into society in two vitally important dimensions after release" (i.e., subsequent employment and criminal convictions).[104]

31. In 2022, Helena Addison, Therese Richmond, Lisa Lewis, and Sara Jacoby published a systematic review of prior studies that focused on the mental

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[102] *Id.* at 423.

[103] *Id.* at 448.

[104] Ibid.

health outcomes of formerly incarcerated Black men.[105] Acknowledging that the "racially and economically disparate distribution of incarceration" disproportionately affects Black men, they also noted that "Black men are also overrepresented in solitary confinement, an experience with known negative mental health consequences, including suicidal ideation."[106] Addison et al. concluded their literature review by observing that although "the experience of incarceration itself negatively impacts mental health outcomes," there is "an association of a history of solitary confinement… with an increased likelihood of experiencing depressive and PTSD symptoms" after release, and likened the prison experiences of "solitary confinement and violence" to a form of institutional trauma that can contribute to the notably poor mental health of formerly incarcerated Black men.[107]

32. In addition to the empirical studies and literature reviews that I have discussed so far, there were several authoritative commentaries that were published by expert groups during this period, each of which reached very similar conclusions about the harmfulness of solitary confinement. The first one was the

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[105] Addison, H., Richmond, T., Lewis, L., & Jacoby, S. (2022). Mental health outcomes in formerly incarcerated Black men: A systematic mixed studies review. *Journal of Advanced Nursing, 78(7),* 1851-1869.

[106] Id. at 1852.

[107] Id. at 1865.

product of a long-standing collaboration between a national organization of high-level correctional administrators, formerly the Association of State Correctional Administrators ("ASCA"), now the Correctional Leaders Association ("CLA"), and the Arthur Liman Center for Public Interest Law ("Liman Center"). The results of nationwide surveys have resulted in a series of monographs ("CLA/Liman Center Reports") on the nature and degree to which solitary confinement is used by correctional systems across the United States. The first of the two most recent ASCA/Liman Center Reports, published in October 2018, referenced the 2016 revision of the American Correctional Association Standards, which the ASCA/Liman Center authors acknowledged as "reflect[ing] the national consensus to limit the use of restrictive housing for pregnant women, juveniles, and seriously mentally ill individuals, as well as not to use a person's gender identity as the sole basis for segregation," a development they noted was consistent with the fact that "[c]orrectional systems around the country are engaging in targeted efforts to reform their practice of isolating prisoners."[108] Commenting on attempts to reduce the use of solitary confinement, undertaken not only by U.S. correctional officials but also by legislatures, courts, and international bodies, the 2018 ASCA/Liman

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[108] Association of State Correctional Administrators & Liman Center for Public Interest Law, *Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell*, (Oct. 2018), at p. 5.

Center Report also acknowledged that "these endeavors reflect the national and international consensus that restrictive housing imposes grave harms on individuals confined, on staff, and on the communities to which prisoners return. Once solitary confinement was seen as a solution to a problem. Now prison officials around the United States are finding ways to solve the problem of restrictive housing."[109] The specific reforms in the nature and use of solitary confinement that the 2018 ASCA/Liman Center Report documented included limiting the use of solitary confinement for only the most serious offenses, explicitly considering less restrictive alternatives before placing someone in solitary confinement (including

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Statement

CONSENSUS STATEMENT FROM THE SANTA CRUZ SUMMIT ON SOLITARY CONFINEMENT AND HEALTH†

BACKGROUND

"Solitary confinement" is known by many different names and acronyms in corrections: "close custody," "administrative segregation," "restrictive housing," and "punitive isolation," to name just a few. Prison and jail administrators use solitary confinement for a variety of reasons, only some of which are officially acknowledged.[1] The reasons include management of disruptive prisoners, punishment for prison and jail disciplinary infractions, and so-called "protective custody" (i.e., to separate prisoners from others for their safety). Although the cutoff for exactly how much time-in-cell constitutes solitary confinement is debatable, it normally entails in-cell confinement for upwards of twenty-two hours a day.[2] Prisoners in solitary confinement are deprived of meaningful social contact for lengths of time that can range from very brief periods to, in extreme cases, several

† As the primary convenors of the Santa Cruz Summit, Craig Haney (UC Santa Cruz), Brie Williams (UC San Francisco) and Cyrus Ahalt (UC San Francisco) served as Reporters, who took responsibility for summarizing the academic literature that was discussed at the Summit, synthesizing the comments made by Summit participants, circulating multiple drafts of the research synthesis and principles to participants, and integrating their feedback until a consensus was reached.

[1] For example, some prison officials are reluctant to acknowledge that solitary confinement is often used for "punishment," even though the punitive nature of the conditions and treatment to which prisoners are subjected suggests that it is.

[2] For example, Rule 44 of the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules") defines solitary confinement as: "the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days." UNITED NATIONS OFFICE ON DRUGS & CRIME, THE UNITED NATIONS STANDARD MINIMUM RULES FOR THE TREATMENT OF PRISONERS (THE NELSON MANDELA RULES) 14 (2015), https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf [https://perma.cc/62U6-Q4SJ] [hereinafter THE NELSON MANDELA RULES]. We acknowledge that there is some degree of arbitrariness to this definition. For example, the meaningfulness of prisoners' out-of-cell time bears on the question of whether and to what degree they are subjected to debilitating isolation. Thus, a prisoner who is confined to his or her cell for fewer than twenty-two hours a day but denied the opportunity to engage in meaningful contact and purposeful activity with others should still be considered "isolated."

decades.[3] The number of persons in solitary confinement worldwide is difficult to reliably calculate. However, in 2014, it was estimated that in the United States alone 80,000 or more persons were held in solitary confinement in the nation's jails and prisons on any given day.[4]

The deprivation of meaningful social contact and interaction that occurs in solitary confinement is a form of trauma and the resulting harm has been well documented. Solitary confinement has been linked to a host of negative psychological and physical symptoms and problematic behaviors, including: anxiety, depression, ruminations, irritability and anger, paranoia, disturbed sleep and appetite, cognitive impairment, social withdrawal, cardiovascular disease, impaired vision, self-harm, and suicide.[5] These adverse effects may

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[3] Although comprehensive data on the number of persons confined in solitary confinement for a decade or more in the United States are difficult to obtain, there are a number of well-known examples. In a lawsuit challenging long-term solitary confinement at California's Pelican Bay, it was determined that more than half the population at the prison (over 500 prisoners) had been there for more than ten years and nearly 100 had been there for over twenty years. Plaintiffs' Second Amended Complaint at 1, Ashker v. Brown, No. 4:09-cv-05796 (N.D. Cal. Sept. 10, 2012). In *Johnson v. Wetzel*, Chief Judge Christopher Conner ordered the release of sixty-four-year-old Pennsylvania prisoner Arthur Johnson, writing, "For the past thirty-six years, the Department [of Corrections] has held Mr. Johnson in solitary confinement—his entire existence restricted, for at least twenty-three hours per day, to an area smaller than the average horse stall. Astoundingly, Mr. Johnson continues to endure this compounding punishment, despite the complete absence of major disciplinary infractions for more than a quarter century." 209 F. Supp. 3d 766, 770 (M.D. Pa. 2016). Perhaps the best known of these cases involved the "Angola Three"—Robert King, Herman Wallace, and Albert Woodfox—who were held in solitary confinement in Louisiana's notorious Angola prison for several decades. The last one of the men to be released, Mr. Woodfox, served more than forty-three years in isolation. David Cole, *Albert Woodfox's Forty Years in Solitary Confinement*, NEW YORKER (June 16, 2015), https://www.newyorker.com/news/news-desk/albert-woodfoxs-forty-years-in-solitary-confinement [https://perma.cc/C59C-46TK]. *See generally* ALBERT WOODFOX WITH LESLIE GEORGE, SOLITARY (2019) (describing his time in solitary).

[4] For example, one national survey of prison administrators who reported figures for their jurisdictions concluded that "it is fair to estimate that some 80,000-100,000 people were in restricted housing in prisons in the fall of 2014." ASS'N OF STATE CORR. ADM'RS & THE LIMAN PROGRAM, YALE LAW SCH., TIME-IN-CELL: THE ASCA-LIMAN 2014 NATIONAL SURVEY OF ADMINISTRATIVE SEGREGATION IN PRISON 10 (2015), https://law.yale.edu/sites/default/files/area/center/liman/document/time-in-cell_combined_-web_august_2015.pdf [https://perma.cc/D5MZ-ESFP] [hereinafter 2015 ASCA-LIMAN REPORT]. Reflecting the current movement toward curbing and reforming the use of solitary confinement, subsequent surveys by the same researchers indicated that the number of persons in restrictive housing in the United States was declining overall. For example, by the fall of 2017, the number had been reduced to approximately 61,000. THE ASS'N OF STATE CORR. ADM'RS & THE LIMAN CTR. FOR PUB. INTEREST LAW AT YALE LAW SCH., REFORMING RESTRICTIVE HOUSING: THE 2018 ASCA-LIMAN NATIONWIDE SURVEY OF TIME-IN-CELL (2018), https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_restrictive_housing_revised_sept_25_2018_-_embargoed_unt.pdf [https://perma.cc/AHW3-PHW5].

[5] *See, e.g.*, SHARON SHALEV, A SOURCEBOOK ON SOLITARY CONFINEMENT 15–17 (2008), http://solitaryconfinement.org/uploads/sourcebook_web.pdf [https://perma.cc/5MGS-3F7R]; Bruce A.

persist after a person's time in solitary confinement has ended, and some of them may prove fatal. For example, a study conducted in the New York City jail system found that fewer than 10% of the population was held in solitary confinement, yet these persons accounted for over 50% of all documented acts of self-harm, and 45% of potentially fatal acts of self-harm.[6]

Although the absence of meaningful social contact is the essence of solitary confinement, the painfulness and potential harm of the experience is compounded by other forms of deprivation. Prisoners in solitary confinement are deprived of access to positive environmental stimulation, meaningful recreation, programming, treatment, contact visits, and other aspects of everyday prison life that are essential to health and rehabilitation. In many instances, solitary confinement is punitively and forcefully imposed. In addition, the atmosphere inside jail and prison isolation units is often hostile, adding to its stressfulness.[7]

The literature documenting the serious adverse consequences that often result from solitary confinement is robust and theoretically well grounded.[8]

Arrigo & Jennifer Leslie Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 INT'L J. OFFENDER THERAPY & COMP. CRIMINOLOGY 622, 627–33 (2008); Kristin G. Cloyes, David Lovell, David G. Allen & Lorna A. Rhodes, *Assessment of Psychosocial Impairment in a Supermaximum Security Unit Sample*, 33 CRIM. JUST. & BEHAV. 760, 773–74 (2006); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 335–38 (2006); Craig Haney, *Restricting the Use of Solitary Confinement*, 1 ANN. REV. CRIMINOLOGY 285, 298–299 (2018); Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQ. 124, 132–137 (2003); Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 529–39 (1997); Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUST. 441, 471–87 (2006).

[6] Fatos Kaba, Andrea Lewis, Sarah Glowa-Kollisch, James Hadler, David Lee, Howard Alper, Daniel Selling, Ross MacDonald, Angela Solimo, Amanda Parsons & Homer Venters, *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 442, 444–46 (2014); *see also* Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 PSYCHIATRIC SERVS. 676 (2008) (discussing the interaction between solitary and suicide).

[7] *See generally, e.g.*, TERRY ALLEN KUPERS, SOLITARY: THE INSIDE STORY OF SUPERMAX ISOLATION AND HOW WE CAN ABOLISH IT (2017) (giving an account of the harsh conditions of supermax facilities); LORNA A. RHODES, TOTAL CONFINEMENT: MADNESS AND REASON IN THE MAXIMUM SECURITY PRISON (2004) (providing first-hand accounts of prison life from both inmates and staff); Craig Haney, *A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons*, 35 CRIM. JUST. & BEHAV. 956 (2008) (describing how the conditions of supermax facilities foster a culture of prisoner mistreatment).

[8] The few studies that have purported to find minimal or no negative effects—most notably the methodologically flawed 2010 O'Keefe study—have been roundly debunked. For a description of the O'Keefe study, see MAUREEN L. O'KEEFE, KELLI J. KLEBE, ALYSHA STUCKER, KRISTIN STURM & WILLIAM LEGGETT, ONE YEAR LONGITUDINAL STUDY OF THE PSYCHOLOGICAL EFFECTS OF ADMINISTRATIVE SEGREGATION (2010), https://www.ncjrs.gov/pdffiles1/nij/grants/232973.pdf

Much of the evidence has existed for many decades and has been collected by researchers from diverse disciplines, operating independently across different continents.[9] In formal recognition of that evidence, a gathering of prominent trauma, mental health, and prison experts at the International Psychological Trauma Symposium in Turkey formulated what came to be known as the "Istanbul Statement on the Use and Effects of Solitary Confinement."[10] The Statement summarized the well-known harms of solitary confinement and concluded that the practice should be employed only in exceptional circumstances, as an absolute last resort, and then only for as short a time as necessary. The document was submitted to the U.N. General Assembly by the Special Rapporteur on Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment in 2008.[11]

[https://perma.cc/L4YY-ACHS], and Jeffrey L. Metzner & Maureen L. O'Keefe, *Psychological Effects of Administrative Segregation: The Colorado Study*, 13 CORRECTIONAL MENTAL HEALTH REP., May/June 2011. Since the study was published, numerous critiques have appeared. *See, e.g.*, Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, 13 CORRECTIONAL MENTAL HEALTH REP., May/June 2011; David Lovell & Hans Toch, *Some Observations About the Colorado Segregation Study*, 13 CORRECTIONAL MENTAL HEALTH REP., May/June 2011; Sharon Shalev & Monica Lloyd, *Though This Be Method, Yet There Is Madness In't: Commentary on* One Year Longitudinal Study of the Psychological Effects of Administrative Segregation, CORRECTIONS & MENTAL HEALTH (June 21, 2011, 10:05 AM), https://community.nicic.gov/blogs/mentalhealth/archive/2011/06/21/though-this-be-method-yet-there-is-madness-in-t-commentary-on-one-year-longitudinal-study-of-the-psychological-effects-of-administrative-segregation.aspx [https://perma.cc/M6CC-CDJC]; Peter Scharff Smith, *The Effects of Solitary Confinement: Commentary on* One Year Longitudinal Study of the Psychological Effects of Administrative Segregation, CORRECTIONS & MENTAL HEALTH (June 21, 2011; 10:07 AM), https://community.nicic.gov/blogs/mentalhealth/archive/2011/06/21/the-effects-of-solitary-confinement-commentary-on-one-year-longitudinal-study-of-the-psychological-effects-of-administrative-segregation.aspx [https://perma.cc/P6E2-Z48G]. For a lengthy critique of the O'Keefe study and the very few others that purport to find no or limited negative effects, see generally Craig Haney, *The Psychological Effects of Solitary Confinement: A Systematic Critique*, 47 CRIME & JUST. 365 (2018).

[9] Although most of the direct research that has been conducted on the psychological effects of solitary confinement pertains to prisons, it is important to acknowledge that the practice is in widespread use in jails or "remands" as well. There is no reason to believe that the same kinds of negative effects that have been documented in prison solitary confinement units do not also occur in comparable units in jails. *See, e.g.*, Craig Haney, Joanna Weill, Shirin Bakhshay & Tiffany Lockett, *Examining Jail Isolation: What We Don't Know Can Be Profoundly Harmful*, 96 PRISON J. 126, 131–134 (2015) (speculating that lack of resources and training often leads to jail guards resorting to solitary as method of controlling inmates).

[10] Istanbul Statement on the Use and Effects of Solitary Confinement (Dec. 9, 2007), http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf [https://perma.cc/NNC5-RLCL5YCF-6UHJ].

[11] Manfred Nowak (Special Rapporteur of the Human Rights Council), *Interim Rep. on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/63/175, at 22 (July 28, 2008).

The pivotal Istanbul Statement was followed by a number of similar statements and guidelines issued by human rights, legal, mental health, and corrections organizations that voiced broad support for comprehensive solitary confinement reform. For example, in 2011, the Special Rapporteur submitted a report to the United Nations that defined solitary confinement for any period longer than fifteen consecutive days as cruel, inhuman, or degrading treatment.[12] That same year, the American Bar Association affirmed the Istanbul Statement's general principle that solitary confinement should be administered in the least restrictive environment and for the shortest period possible.[13] The Canadian Office of Correctional Investigator (the official ombudsman overseeing the treatment of prisoners in the Canadian prison system) recommended that Canada

> significantly limit the use of administrative segregation, prohibit its use for inmates who are mentally ill and for younger adults (up to 21 years of age), impose a ceiling of no more than 30 continuous days, and introduce judicial oversight or independent adjudication for any subsequent stay in segregation beyond the initial 30 day placement.[14]

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[12] Juan E. Méndez (Special Rapporteur of the Human Rights Council), *Rep. on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U.N. Doc. A/66/268, at 21 (Aug. 5, 2011).

[13] *See* AM. BAR ASS'N, CRIMINAL JUSTICE STANDARDS: STANDARDS ON TREATMENT OF PRISONERS (2010), https://www.americanbar.org/groups/criminal_justice/publications/criminal_justice_section_archive/crimjust_standards_treatmentprisoners/ [https://perma.cc/YJ5A-VGJG]. In the summer of 2015, (ASCA) issued a statement describing "prolonged isolation of individuals in jails and prisons" as a "grave problem in the United States." 2015 ASCA-LIMAN REPORT, *supra* note 4, at 1.

[14] *Backgrounder: 42nd Annual Report to Parliament*, OFF. OF THE CORRECTIONAL INVESTIGATOR (Nov. 30, 2015), https://www.oci-bec.gc.ca/cnt/comm/presentations/presentationsAR-RA1415info-eng.aspx [https://perma.cc/J4CB-45EG]. In addition, in 2016 the American Correctional Association (ACA) issued revised standards for accreditation of prisons that provided, for the first time, time-based categories of restrictive housing. While the Nelson Mandela Rules provided a cutoff of fifteen days, beyond which the practice became "prolonged solitary confinement," which was to be banned, the ACA policies distinguished between "restrictive housing," which it defined as requiring a prisoner "to be confined to a cell at least 22 hours per day," and "extended restrictive housing," defined as separating a prisoner "from contact with general population while restricting [the prisoner] to his/her cell for at least 22 hours per day and for more than 30 days." The ACA stated that prisons and local detention facilities should not place individuals "under the age of 18," pregnant prisoners, or people with "serious mental illness" in Extended Restrictive Housing. Further, correction systems were not to use gender identity alone as the basis for restrictive housing. In terms of exit policies, the ACA called on jurisdictions to have written policies, practices, and procedures that avoided releasing persons from extended restrictive housing directly into the community. *See* AM. CORR. ASS'N, RESTRICTIVE HOUSING PERFORMANCE BASED STANDARDS (2016), http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards___Accreditation/Standards/Restrictive_Housing_Committee/ACA_Member/Standards_and_Accreditation/Restrictive_Housing_Committee/Restrictive_Housing_Committee.aspx?hkey=458418a3-8c6c-48bb-93e2-b1fcbca482a2 [https://perma.cc/J7KJ-X98Y].

In subsequent years, multiple associations of healthcare professionals, including the American Psychiatric Association, American Psychological Association, British Medical Association, and the Israeli Medical Association, issued similar calls for reform.[15] The movement toward significant reform accelerated in December 2015 when the U.N. General Assembly adopted the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules").[16] Underscoring the magnitude of the harm that solitary confinement can inflict and the urgency of restricting its use, the Nelson Mandela Rules established a new framework for reform. In addition to reaffirming the Istanbul Statement, the Mandela Rules called for a prohibition against the use of "prolonged solitary confinement" in excess of fifteen consecutive days, which it defined as torture.[17]

The United States holds nearly a quarter of the world's incarcerated population.[18] It is also regarded as a "world leader" in the use of solitary

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[15] *See, e.g.*, AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS (2012), https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-prisoners-segregation.pdf [https://perma.cc/MNQ5-XPLK] [hereinafter POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS]; AM. PSYCHOLOGICAL ASS'N, SOLITARY CONFINEMENT OF JUVENILE OFFENDERS (2016), https://www.apa.org/advocacy/criminal-justice/solitary.pdf [https://perma.cc/2NVC-NLJM]; *see also* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-429, BUREAU OF PRISONS: IMPROVEMENTS NEEDED IN BUREAU OF PRISONS' MONITORING AND EVALUATION OF IMPACT OF SEGREGATED HOUSING (2013), https://www.gao.gov/assets/660/654349.pdf [https://perma.cc/AE9Y-2L9T] (drawing attention to the fact that although the Federal Bureau of Prisons (BOP) housed approximately 7% of its prisoners in some form of "segregated housing" it had failed to ever assess the impact of the practice "on institutional safety or the impacts of long-term segregation on inmates"). The British Medical Association, in a joint statement with the Royal College of Psychiatrists and Royal College of Paediatrics and Child Health, called for "an end to the use of solitary confinement on children and young people detained in the youth justice system," and issued guidelines for physicians to follow "[u]ntil solitary confinement is abolished." BRITISH MED. ASS'N, ROYAL COLL. OF PSYCHIATRISTS & ROYAL COLL. OF PAEDIATRICS & CHILD HEALTH, JOINT POSITION STATEMENT ON SOLITARY CONFINEMENT OF CHILDREN AND YOUNG PEOPLE (2018), https://www.bma.org.uk/media/1859/bma-solitary-confinement-in-youth-detention-joint-statement-2018.pdf [https://perma.cc/4WYQ-DLUU] [hereinafter JOINT STATEMENT]. In 2009, the Israeli Medical Association issued a formal statement acknowledging that solitary confinement "has a negative effect on the mental and physical health of the prisoner" and prohibited its members from taking part in "punitive measures against a prisoner" and from giving "medical approval for isolation or separation." *Prohibition of Physician Participation in the Isolation or Separation of Prisoners*, ISRAELI MED. ASS'N (Apr. 2009), http://www.ima.org.il/eng/ViewCategory.aspx?CategoryId=7749 [https://perma.cc/5QQQ-XFT7].

[16] NELSON MANDELA RULES, *supra* note 2, at 1.

[17] *Id.* at 14.

[18] ROY WALMSLEY, WORLD PRISON BRIEF & INST. FOR CRIMINAL POLICY RESEARCH, WORLD PRISON POPULATION LIST 18 (12th ed. 2018), https://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf [https://perma.cc/2PEK-AVRX]

confinement and the "inventor" of so-called "supermax" prisons (modern facilities devoted to the long-term, extreme isolation of large numbers of prisoners). As a result, legal and correctional developments designed to significantly limit the use of solitary confinement in the United States are particularly notable. For example, since 1995, federal judges in California, Texas, Wisconsin, and Indiana have issued opinions limiting the use of solitary confinement, including finding that placing mentally ill prisoners in isolation is unconstitutional.[19]

More recently, settlements in cases in California, Massachusetts, and New York resulted in significant modifications to, or the outright prohibition of, certain forms of solitary confinement and the use of solitary confinement for certain groups of prisoners. For example, in California, following a decision by the court that the existing system of segregation still violated constitutional standards for prisoners with serious mental illness, a new remedial plan was approved that required wholly separate units with enhanced privileges and programs, mental health treatment, and out-of-cell time for this vulnerable population.[20] In another California case, a lawsuit over the use of long-term solitary confinement settled with terms that significantly limited the use of isolation in the nation's second largest state prison system.[21] This settlement drastically reduced the number of prisoners housed in one of the nation's most notorious solitary confinement units, the security housing unit (SHU) at Pelican Bay prison. As a result of these two

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[19] *See, e.g.*, Ind. Prot. & Advocacy Serv. Comm'n v. Comm'r, Ind. Dep't of Corr., No. 1:08-cv-01317-TWP-MJD, 2012 WL 6738517, at *23 (S.D. Ind. Dec. 31, 2012) (stating that "it is inconceivable that any representative portion of society would put its imprimatur on a plan to subject . . . mentally ill . . . inmates . . . to the SHU, knowing that severe psychological consequences will most probably befall those inmates," and that their continued confinement in an Indiana prison "deprives inmates of a minimal civilized level of one of life's necessities"); Jones'El v. Berge, 164 F. Supp. 2d 1096, 1123–24 (W.D. Wis. 2001) (observing conditions of isolation at a particular facility "pose[d] a grave risk of harm to seriously mentally ill inmates" and concluding they should "not be housed" there); Ruiz v. Johnson, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999) (concluding that "[a]s to mentally ill inmates [in solitary confinement], the severe and psychologically harmful deprivations" in the Texas prison system are "by our evolving and maturing . . . standards of humanity and decency, found to be cruel and unusual punishment"); Madrid v. Gomez, 889 F. Supp. 1146, 1266–67 (N.D. Cal. 1995) (finding "a substantial or excessive risk of harm with respect to inmates who were mentally ill or otherwise particularly vulnerable to conditions of extreme isolation and reduced environmental stimulation" presented by solitary confinement).

[20] *See* Coleman v. Brown, 28 F. Supp. 3d 1068, 1095, 1098–1104 (E.D. Cal. 2014) (concluding that "the overwhelming weight of the evidence in the record is that placement of seriously mentally ill prisoners in California's segregated housing units can and does cause serious psychological harm, including decompensation, exacerbation of mental illness, inducement of psychosis, and increased risk of suicide," and ordering a series of remedies intended to address these facts).

[21] *See* Ashker v. Governor of Cal., No. C 09-05796 CW, 2016 WL 4770013, at *1 (N.D. Cal. Sept. 14, 2016).

cases, and other reforms, California reduced the percentage of its prison population in segregation to under 4%[22] and greatly reduced the use of segregated housing for prisoners with mental illness.[23]

Moreover, correctional leaders in several U.S. states—including California, Colorado, Maine, New York, North Dakota, Ohio, Oregon, and Washington—have initiated reforms to significantly limit the use of solitary confinement in their prison systems. Summarizing these trends, a joint report of the Association of State Correctional Administrators (ASCA) and the Arthur Liman Center for Public Interest Law (ASCA-Liman Report) noted:

> [D]ozens of initiatives are underway to reduce the degree and duration of isolation, or to ban it outright, and to develop alternatives to protect the safety and well-being of the people living and working in prisons. The harms of such confinement for prisoners, staff, and the communities to which prisoners return upon release are more than well-documented. In some jurisdictions, isolated confinement has been limited or abolished for especially vulnerable groups (the mentally ill, juveniles, and pregnant women), and across the country, correctional directors are working on system-wide reforms for all prisoners.[24]

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[22] For example, between 2015 and 2017, the percentage of prisoners held in administrative segregation, security housing units, and short- and long-term restricted housing in California prisons, was reduced from 6% to 3.3% of the total prisoner population. The number of prisoners housed in that prison system's problematic security housing units or "SHUs" was reduced from 3018 to 579. CAL. DEP'T OF CORR. & REHAB., OFFICE OF RESEARCH, DIV. INTERNAL OVERSIGHT AND RESEARCH, OFFENDER DATA POINTS: OFFENDER DEMOGRAPHICS FOR THE 24-MONTH PERIOD ENDING JUNE 2017, at 9 (2017), https://www.cdcr.ca.gov/research/wp-content/uploads/sites/174/2019/08/DataPoints_062017.pdf [https://perma.cc/9S6A-ZC5Y]. In addition to these reductions in California, systemwide litigation in two other states addressed overall conditions of confinement and led to significant modifications in the nature and use of solitary confinement. Specifically, a settlement reached in an Arizona statewide class action limited and reformed solitary confinement practices there. *See* Parsons v. Ryan, 784 F.3d 571, 572 n.1, 573 (9th Cir. 2015) (Ikuta, J., dissenting). In Alabama, a landmark federal court decision included a number of wide-reaching reforms to the state's segregation units and practices. *See* Braggs v. Dunn, 257 F. Supp. 3d 1171, 1267–68 (M.D. Ala. 2017). In addition to these cases in the United States, several Canadian courts—one in British Columbia and another in Ontario—ruled that the practices of prolonged (fifteen days or more) and indefinite segregation were unconstitutional. *See* B.C. Civil Liberties Ass'n v. Att'y Gen. of Can., [2019] BCCA 228 (Can.); Corp. of the Canadian Civil Liberties Ass'n v. Att'y Gen. of Can., [2017] ONSC 7491 (Can.).

[23] Order at 2, Coleman v. Brown, No. CIV. S-90-520 LKK/DAD (PC) (E.D. Cal. Aug. 29, 2014); *see also* Erica Goode, *Federal Judge Approves California Plan to Reduce Isolation of Mentally Ill Inmates*, N.Y. TIMES (Aug. 29, 2014), https://www.nytimes.com/2014/08/30/us/california-plans-to-reduce-isolation-of-mentally-ill-inmates.html [https://perma.cc/25XM-RQEN].

[24] 2015 ASCA-LIMAN REPORT, *supra* note 4, at 7. The same group of researchers has empirically documented the trend toward reductions in the use of prison isolation in the United States. *See* THE ASS'N OF STATE CORR. ADM'RS & THE LIMAN CTR. FOR PUB. INTEREST LAW AT YALE LAW SCH., REFORMING RESTRICTIVE HOUSING: THE 2018 ASCA-LIMAN NATIONWIDE SURVEY OF TIME-IN-CELL 10–56 (2018), https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_restrictive_housing_revised_sept_25_2018_-_embargoed_unt.pdf [https://perma.cc/SF4E-5XTH].

The ASCA-Liman Report expanded the discussion about solitary confinement reform to include the likely harm that correctional staff working in these high-stress units may incur, as well as the unintended consequence of potentially undermining public safety. Nearly all incarcerated adults—including those who have spent time in solitary confinement—will return to their communities.[25] Yet, perhaps in part because of lost opportunities for rehabilitative programming while in solitary confinement and in part because of the potentially disabling psychological effects in the aftermath of the experience, time spent in isolation may compromise community reintegration and increase the likelihood of recidivism.[26]

I. THE SANTA CRUZ SUMMIT

In May 2018, international experts convened in Santa Cruz, California for a Summit on solitary confinement. The purpose of the Summit was to review and discuss current knowledge regarding the broad effects of the practice, including its current scientific, correctional, and human rights

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[25] *See, e.g.*, TIMOTHY HUGHES & DORIS JAMES WILSON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, REENTRY TRENDS IN THE UNITED STATES (2004), https://www.bjs.gov/content/pub/pdf/reentry.pdf [https://perma.cc/U2XB-GNCD] ("At least 95% of all State prisoners will be released from prison at some point . . . .").

[26] There are data on recidivism both inside prison and in free society. No empirical evidence indicates that the experience of solitary confinement reduces subsequent disciplinary infractions or criminal behavior in either place, and some evidence suggests that it may increase both. *See, e.g.*, H. Daniel Butler, Benjamin Steiner, Matthew D. Makarios & Lawrence F. Travis, III, *Assessing the Effects of Exposure to Supermax Confinement on Offender Postrelease Behaviors*, 97 PRISON J. 275, 287–88 (2017); David Lovell, L. Clark Johnson & Kevin C. Cain, *Recidivism of Supermax Prisoners in Washington State*, 53 CRIME & DELINQ. 633, 643–45 (2007) [hereinafter Lovell et al., *Recidivism of Supermax Prisoners*]; Daniel P. Mears & William D. Bales, *Supermax Incarceration and Recidivism*, 47 CRIMINOLOGY 1131, 1149–50 (2009); Justine A. Medrano, Turgut Ozkan & Robert Morris, *Solitary Confinement Exposure and Capital Inmate Misconduct*, 42 AM. J. CRIM. JUST. 863, 877–78 (2017) (exploring the effect of exposure to short-term solitary confinement among violent prison inmates); Kristen M. Zgoba, Jesenia M. Pizarro & Laura M. Salerno, *Assessing the Impact of Restrictive Housing on Inmate Post-Release Criminal Behavior*, 45 AM. J. CRIM. JUST. 102, 112, 117 (2020). In addition, there is separate but related evidence that the negative psychological changes that occur in solitary confinement may persist after persons are released. *See, e.g.*, HUMAN RIGHTS IN TRAUMA MENTAL HEALTH LAB, STANFORD UNIV., MENTAL HEALTH CONSEQUENCES FOLLOWING RELEASE FROM LONG-TERM SOLITARY CONFINEMENT IN CALIFORNIA 18–22 (2017), https://ccrjustice.org/sites/default/files/attach/2018/04/CCR_StanfordLab-SHUReport.pdf [https://perma.cc/9XG7-MT4W]; Terry A. Kupers, *What to Do with the Survivors?: Coping with the Long-Term Effects of Isolated Confinement*, 35 CRIM. JUST. & BEHAV. 1005, 1011–12 (2008). In fact, recent research suggests that persons exposed to solitary confinement have much higher postprison mortality rates than other formerly incarcerated persons, including deaths from suicide. *See* Lauren Brinkley-Rubinstein, Josie Sivaraman, David L. Rosen, David H. Cloud, Gary Junker, Scott Proescholdbell, Meghan E. Shanahan & Shabbar I. Ranapurwala, *Association of Restrictive Housing During Incarceration with Mortality After Release*, JAMA NETWORK OPEN, Oct. 2019, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2752350 [https://perma.cc/4GV7-FW6Y].

status, the ethical principles that should govern its use, and the most important directions for reform. The meeting was timed to coincide with the tenth anniversary of the Istanbul Statement and to acknowledge that, despite the development of critical evidence and new guidelines, and the implementation of significant reforms in the decade that followed, prolonged solitary confinement continues to be used around the world. In some countries, it remains a common practice that affects thousands of people every day, including tens of thousands of people in the United States alone.[27] To advance solitary confinement reform based on the wealth of accumulated knowledge about its harmful effects, Summit participants developed a set of guiding principles to inform significant science- and ethics-based changes to the correctional policies that can and should govern this practice.

The participants were invited to the Summit on the basis of their experience with and knowledge about solitary confinement, law, international standards for the treatment of prisoners, human rights, prison health care, and prison reform. The list of invitees was comprehensive but by no means exhaustive. Participants were intentionally drawn from a variety of different professions, including mental health, medicine, corrections, law, academia, and prison advocacy. They included researchers, clinicians, practicing lawyers, correctional officials and staff, human rights experts and advocates, and persons engaged in correctional monitoring and oversight.

The goal of the Summit was to produce a set of guiding principles to advance solitary confinement reform in the United States and internationally. During the first day of the Summit, attendees participated in a series of expert panels and open discussions in which they shared their knowledge about solitary confinement policies and practices, the effects of jail and prison isolation, and ongoing reform efforts. On the second day, participants were separated into four working groups, each of which included persons with

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[27] JUAN E. MÉNDEZ, ALEXANDER PAPACHRISTOU, ERIC ORDWAY, AMY FETTIG & SHARON SHALEV, SEEING INTO SOLITARY: A REVIEW OF THE LAWS AND POLICIES OF CERTAIN NATIONS REGARDING SOLITARY CONFINEMENT OF DETAINEES 21 (2016), https://www.weil.com/~/media/files/pdfs/2016/un_special_report_solitary_confinement.pdf [https://perma.cc/C97K-C2NL]; Manfred Nowak, *Global Perspectives on Solitary Confinement—Practices and Reforms Worldwide*, *in* SOLITARY CONFINEMENT: EFFECTS, PRACTICES, AND PATHWAYS TOWARD REFORM 51–54 (Jules Lobel & Peter Scharff Smith eds., 2019); Sharon Shalev, *Solitary Confinement Across Borders*, *in* SOLITARY CONFINEMENT: EFFECTS, PRACTICES, AND PATHWAYS TOWARD REFORM, *supra*, at 60–62; Daniella Johner, *"One Is the Loneliest Number": A Comparison of Solitary Confinement Practices in the United States and the United Kingdom*, 7 PENN. ST. J.L. & INT'L AFF. 229, 230 (2019) (citing David H. Cloud, Ernest Drucker, Angela Browne & Jim Parsons, *Public Health and Solitary Confinement in the United States*, 105 AM. J. PUB. HEALTH 18, 18 (2015)); Elisa Mosler, *Solitary Confinement in Great Britain: Still Harsh, but Rare*, SOLITARY WATCH (Jan. 19, 2012), http://solitarywatch.com/2012/01/19/solitary-confinement-in-greatbritain-still-harsh-but-rare/ [https://perma.cc/J3WH-YRJD].

different specialized expertise. Each working group deliberated on one of four overarching areas or sets of issues that emerged from the prior day's discussions. The areas were agreed upon by consensus and included: harm to individuals living or working in solitary confinement units; the role of healthcare professionals in solitary confinement and solitary confinement reform; prospects for correctional policy change and implementation; and external monitoring and oversight. Although participants acknowledged the critical role that litigation has and will continue to play in solitary confinement reform in the United States, the specific principles and priorities developed were intended to extend well beyond existing legal parameters to accomplish broader reform.

II. REACHING CONSENSUS ON GUIDING PRINCIPLES

The Summit panel presentations, roundtable discussions, and working groups led to a consensus on eight guiding principles to achieve meaningful and lasting reform of solitary confinement policies and practices. The principles are summarized in Table 1.

TABLE 1: GUIDING PRINCIPLES

The Santa Cruz Summit on Solitary Confinement and Health reaffirms the Istanbul Statement as an appropriate framework for reforming solitary confinement. Existing research clearly establishes that solitary confinement subjects prisoners to significant risk of serious harm and it therefore should be used only when absolutely necessary, and only for the shortest amount of time possible.
The Summit reaffirms that the use of solitary confinement should be absolutely prohibited for certain groups of especially vulnerable persons, including the mentally ill, children, older adults, people with chronic health conditions that are treated with exercise (e.g., diabetes and heart disease) and pregnant women. Prohibitions for additional groups of people may become necessary if emerging evidence indicates such exclusions are warranted.
Reduction in the use of solitary confinement should be further informed by the growing evidence-based knowledge that prolonged isolation accomplishes few if any legitimate penological purposes and, conversely, that it is likely to impede rehabilitation and community reintegration.
Solitary confinement reform is consistent with ongoing efforts to address and enhance correctional officer health and wellness, which can be adversely affected by the inhumane conditions and practices that often exist inside isolation units.
The unique ethical challenges faced by correctional medical and mental health care providers who work inside solitary confinement units are not easily resolved and serve as additional professional justifications for greatly restricting its use and prohibiting outright especially vulnerable populations from being subjected to the practice.

Meaningful forms of independent external and internal monitoring and oversight are essential to buttress and advance solitary confinement reform and should aid in reducing the considerable variation in policy and practice between different correctional systems.
As more prison systems significantly limit or eliminate solitary confinement, it is important that stakeholders document and disseminate evidence about the impact of these reforms, including that well-designed, properly implemented changes can reduce harm to incarcerated persons and correctional staff and, in many cases, enhance public safety and security inside correctional facilities and for the public at large.
Because the overuse of solitary confinement reflects and is related to dysfunction in the larger correctional systems in which it is deployed, its reform should be recognized as part of the broader movement to reform prisons generally and to end the overuse of incarceration and the policies and practices that give rise to it.

III. COMMENTARY

Guiding Principle 1. The Santa Cruz Summit on Solitary Confinement and Health reaffirms the Istanbul Statement as an appropriate framework for reforming solitary confinement. Existing research clearly establishes that solitary confinement subjects prisoners to significant risk of serious harm. Therefore, it should be used, if ever, only when absolutely necessary, and only for the shortest amount of time possible. Participants in the Santa Cruz Summit agreed that solitary confinement is a form of psychological and physical trauma that places prisoners at significant risk of serious harm. The scientific literature on solitary confinement, and related scientific research on the harmfulness of social isolation in general, represents an empirical basis for reform. We endorse the conclusions reached in the Istanbul Statement, which itself built on arguments by the United Nations, the European Committee for the Prevention of Torture (CPT) and others, that prolonged solitary confinement constitutes cruel, inhuman, and degrading treatment (CIDT) and torture, and call for its elimination. More than ten years after the Istanbul Statement, the empirical evidence remains robust and the theoretical framework in which it is interpreted—that meaningful social contact is a fundamental human need—has become even more elaborate and well substantiated.[28] Summit participants thus reaffirm the Istanbul Statement's primary conclusion: *solitary confinement should be used only in exceptional circumstances, as a last resort, and for as short a time as possible.*

[28] *See, e.g.*, Craig Haney, *The Science of Solitary: Expanding the Harmfulness Narrative*, 115 NW. U. L. REV. 211, 235–41 (2020) (discussing the relevance of the large body of scientific research on the harmful effects of social isolation on society at large).

Guiding Principle 2. The Summit reaffirms that the use of solitary confinement should be absolutely prohibited for certain groups of especially vulnerable prisoners. In addition to excluding the mentally ill, children, and pregnant women, consideration should be given to prohibiting additional groups of prisoners from being placed in solitary confinement based on emerging evidence that such prohibitions may be warranted. The Istanbul Statement called for the exclusion of specific vulnerable populations from solitary confinement for any length of time, including: the mentally ill, children, pregnant women, and prisoners placed in isolation exclusively because they have received life sentences. Although we recognize that all prisoners are "vulnerable" to the harmful effects of solitary confinement, certain subpopulations are especially so. For example, solitary confinement can be particularly devastating to the mentally ill and to children; its use with both populations has been the target of significant reform. For example, the American Academy of Child and Adolescent Psychiatry called for a prohibition against placing juveniles in solitary confinement, and the American Psychiatric Association and the American Public Health Association recommended the exclusion of prisoners with serious mental illness from isolated confinement lasting four weeks or longer.[29] More recently, the British Medical Association, the Royal College of Paediatrics and Child Health, and the Royal College of Psychiatrists issued a joint position statement identifying solitary confinement as a harmful practice and calling for a prohibition on its use with children and young people.[30]

A greater understanding of the serious harm created by solitary confinement may justify an expansion in the categories of vulnerable populations that should be excluded outright from solitary confinement, including: older adults (age fifty-five or older), for whom recent research has shown that, on average, loneliness accelerates functional decline and hastens death; adults with cognitive and/or functional impairment(s) or disabilities, for whom evidence suggests restricted living environments and/or restricted access to exercise and movement accelerates the impairment and/or

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[29] *See, e.g.*, *Solitary Confinement of Juvenile Offenders*, AM. ACAD. OF CHILD AND ADOLESCENT PSYCHIATRY (Apr. 2012), https://www.aacap.org/aacap/Policy_Statements/2012/Solitary_Confinement_of_Juvenile_Offenders [https://perma.cc/22LM-C2V6] [hereinafter *Solitary Confinement of Juvenile Offenders*]; *Solitary Confinement as a Public Health Issue*, AM. PUB. HEALTH ASS'N (Nov. 5, 2013), https://apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue [https://perma.cc/564H-7CBM] [hereinafter *Solitary Confinement as a Public Health Issue*].

[30] JOINT STATEMENT, *supra* note 15.

disability; and adults with serious chronic medical conditions for which restrictive housing could adversely affect treatment or management (including but not limited to those with conditions for which routine exercise and movement is a first-line treatment, such as diabetes, hypertension, obesity, history of cerebrovascular disease and/or heart disease).[31]

These additions would better align correctional practice with the humane standard implied by the exclusion of the mentally ill, children, and pregnant women: that is, solitary confinement should not be used in any case where there is a high likelihood that it will further damage a prisoner's health or well-being. Of course, enumerated prohibitions do not imply or suggest that solitary confinement is unproblematic for prisoners without identifiable vulnerabilities. There is no evidence that prolonged solitary confinement is psychologically or medically "safe" for anyone. This is why it should only ever be used in exceptional circumstances, to prevent immediate harm, and even then, for as short a time as possible.

Guiding Principle 3. Reductions in the use of solitary confinement should be further informed by the growing evidence-based knowledge that prolonged isolation accomplishes few if any legitimate penological purposes and, conversely, that it is likely to impede rehabilitation and community reintegration. Santa Cruz Summit participants agreed there is no reliable empirical evidence that the use of solitary confinement accomplishes any legitimate penological purpose, except in extremely limited exigent, exceptional, or immediate safety-related circumstances.[32] There is no evidence that solitary confinement achieves long-term reductions

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[31] For example, data generated in the course of the *Ashker v. Governor of California* litigation indicated that prolonged solitary confinement increases the risk of hypertension compared to housing in maximum security units. *See* Expert Report of Louise C. Hawkley at 3–7, Ashker v. Governor of Cal., No. 4:09-cv-05796-CW (N.D. Cal. Sept. 14, 2016), 2016 WL 4770013. A subsequent analysis of these data found that this incremental risk to cardiovascular health likely generates tens of millions of dollars in avoidable lifetime healthcare costs and results in the loss of thousands of quality-adjusted years of life in the United States alone. *See* Brie A. Williams, Amanda Li, Cyrus Ahalt, Pamela Coxson, James G. Kahn & Kirsten Bibbins-Domingo, *The Cardiovascular Health Burdens of Solitary Confinement*, 34 J. GEN. INTERNAL MED. 1977, 1978–79 (2019). Note also that the health risks of the free world analogues of solitary confinement—social isolation, social exclusion, loneliness, and the deprivation of caring human touch—are serious and well documented. *See, e.g.*, Caitlin E. Coyle & Elizabeth Dugan, *Social Isolation, Loneliness and Health Among Older Adults*, 24 J. AGING & HEALTH 1346, 1357–58 (2012); Brett Friedler, Joshua Crapser & Louise McCullough, *One Is the Deadliest Number: The Detrimental Effects of Social Isolation on Cerebrovascular Diseases and Cognition*, 129 ACTA NEUROPATHOLOGY 493, 504 (2015); Julianne Holt-Lunstad, Timothy B. Smith & J. Bradley Layton, *Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review*, 10 PERSPS. PSYCH. SCI. 227 (2015).

[32] Exigent or exceptional circumstances would include the rare instance in which a prisoner must be separated from others on a short-term basis to ensure his or her safety or the immediate safety of others.

in prison violence, overall or in individual cases, and no evidence that it is a successful mechanism for the control or reduction of prison gangs.[33] If rare exigent or exceptional circumstances exist that justify its use (i.e., imminent danger to self or others), solitary confinement should be limited to as short a period as absolutely necessary (i.e., from a few hours to no more than a fifteen-day maximum). Thereafter, persons placed in solitary confinement should be returned to the least restrictive housing conditions possible, and correctional and clinical staff must develop a longer-term plan to maintain safety that does not rely exclusively on isolation.[34]

In addition to the lack of any reliable evidence that solitary confinement achieves legitimate penological goals, there is reason to believe that it operates at cross-purposes with a number of them. There is no recognized theory of rehabilitation or program of positive behavior change that relies on prolonged isolation. To the contrary, regimes of harsh punishment and deprivation are generally regarded as counterproductive in these efforts. Instead, substantial evidence shows that prolonged solitary confinement has harmful and potentially disabling psychological and medical consequences, may increase rather than decrease the likelihood of subsequent recidivism,[35] and is unquestionably more expensive than other forms of confinement. The fact that solitary confinement incurs significant physical, psychological, and economic costs yet fails to achieve even limited penological goals renders the practice even more problematic and less justifiable.

Guiding Principle 4. Solitary confinement reform is consistent with ongoing efforts to address and enhance correctional officer health and

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[33] *See generally, e.g.*, MARK COLVIN, THE PENITENTIARY IN CRISIS: FROM ACCOMMODATION TO RIOT IN NEW MEXICO (1992) (documenting widespread abuse of inmates and arguing that, given the conditions of overcrowding and violence, prisons do not serve the putative purpose of rehabilitation); SHARON SHALEV, SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT (Taylor & Francis 2011) (exploring the dynamics of supermax prisons—from physical design to the social interactions between prisoners and guards—and questioning solitary confinement's continued use in light of its failures); Chad S. Briggs, Jody L. Sundt & Thomas C. Castellano, *The Effect of Supermaximum Security Prisons on Aggregate Levels of Institutional Violence*, 41 CRIMINOLOGY 1341, 1367–70 (2003). *See also* Robert G. Morris, *Exploring the Effect of Exposure to Short-Term Solitary Confinement Among Violent Prison Inmates*, 32 J. QUANTITATIVE CRIMINOLOGY 1, 17, 19–20 (2016); Keramet A Reiter, *Parole, Snitch, or Die: California's Supermax Prisons and Prisoners, 1997–2007*, 14 PUNISHMENT & SOC'Y 530, 541–43 (2012); Jody L. Sundt, Thomas C. Castellano & Chad S. Briggs, *The Sociopolitical Context of Prison Violence and Its Control: A Case Study of Supermax and Its Effect in Illinois*, 88 PRISON J. 94, 115–18 (2008).

[34] Indefinite use of solitary confinement (for example, using consecutive fifteen-day placements) does not constitute an appropriate long-term correctional plan. Reaching the fifteen-day maximum period should trigger an immediate review to determine an alternative and more appropriate plan for the prisoner's care.

[35] Lovell et al., *Recidivism of Supermax Prisoners*, *supra* note 26, at 643–45.

wellness, which can be adversely affected by the inhumane conditions and practices that often exist inside isolation units. In the years since the Istanbul Statement was issued, a small but growing body of research has documented a genuine health "crisis" in the correctional workforce. Preliminary evidence and expert opinion suggest that this crisis is linked to the dehumanizing and often violent environments in which staff work.[36] In the United States, the life expectancy of a correctional officer is less than sixty years—more than fifteen years less than the national average for men.[37] They report trauma at nearly twice the rate of military veterans and one study found that one in ten officers had contemplated suicide. Perhaps not surprisingly, a host of stress-related maladies—including cardiovascular disease, diabetes, substance use disorders, and other chronic illnesses—are disproportionately prevalent in this workforce.[38]

The limited literature on health and wellness in the correctional workforce has not yet established a direct, specific link between these adverse outcomes and working in high-stress, high-security, and dehumanizing isolation units.[39] However, U.S. prison systems that have undertaken solitary confinement reform report marked improvement along a number of dimensions, including in staff morale associated with measured

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[36] Much of this research has been conducted in prison systems in the United States, but there is no reason to believe that the same kind of dehumanizing and morally disengaging work environments, to the extent that they exist in other prison systems in different countries, would result in significantly different outcomes. For a conceptual analysis of the way that key aspects of correctional environments may affect the behavior of correctional staff as well as prisoners, see generally Joanna Weill & Craig Haney, *Mechanisms of Moral Disengagement and Prisoner Abuse*, 17 SOC. ISSUES & PUB. POL'Y 286, 295–311 (2017) (arguing that "routine prison practices and procedures" cause correctional officers to become morally disengaged from their actions, which in turn leads to more abuse of prisoners).

[37] JAIME BROWER, U.S. DEP'T OF JUSTICE OFFICE OF JUSTICE PROGRAMS DIAGNOSTIC CTR., CORRECTIONAL OFFICER WELLNESS AND SAFETY LITERATURE REVIEW 10 (2013).

[38] *See, e.g.*, MICHAEL D. DENHOF & CATERINA G. SPINARIS, DESERT WATERS CORR. OUTREACH, PREVALENCE OF TRAUMA-RELATED HEALTH CONDITIONS IN CORRECTIONAL OFFICERS: A PROFILE OF MICHIGAN CORRECTIONS ORGANIZATION MEMBERS (2016), http://desertwaters.com/wp-content/uploads/2016/07/MCO-Paper_FINAL.pdf [https://perma.cc/CS2V-R4TJ]; AMY E. LERMAN, UNIV. OF CAL., BERKELEY, OFFICER HEALTH AND WELLNESS: RESULTS FROM THE CALIFORNIA CORRECTIONAL OFFICERS SURVEY (2017), https://gspp.berkeley.edu/assets/uploads/research/pdf/executive_summary_08142018.pdf [https://perma.cc/W8GD-VUKH]; Frances E. Cheek & Marie Di Stefano Miller, *The Experience of Stress for Correction Officers: A Double-Bind Theory of Correctional Stress*, 11 J. CRIM. JUST. 105, 106–07, 110–13 (1983); Colette Peters, *Investing in People: Improving Corrections Staff Health and Wellness. Notes from the Field Series*, NAT'L INST. OF JUST. (Aug. 28, 2018), https://nij.ojp.gov/topics/articles/investing-people-improving-corrections-staff-health-and-wellness [https://perma.cc/VWL6-HTWA].

[39] Because officers typically transfer among numerous units over the course of a career, establishing such a scientific link presents a number of methodological and ethical challenges.

reductions in staff's use of force and staff assaults.[40] Other systems that have invested in staff wellness view changes to the working environment, particularly in their most restrictive units, as essential to addressing the crisis in correctional staff health. As health and wellness among correctional staff continues to motivate policy change, it is important to emphasize the ways in which solitary confinement reform can significantly benefit correctional staff as well as prisoners.

Guiding Principle 5. The unique ethical challenges faced by correctional medical and mental health care providers who work inside solitary confinement units are not easily resolved and serve as additional professional justifications for greatly restricting its use and prohibiting outright especially vulnerable populations from being subjected to the practice. Whether providing medical and mental health care to people held in solitary confinement can be consistent with the ethical practice of medicine and mental health care is a difficult, ongoing debate.[41] This is especially true when the correctional purpose for the care is to restore or maintain the prisoner in order to initiate or prolong his retention in solitary confinement.

For example, one important provision of the Nelson Mandela Rules, Rule 46, affirms the general principle of medical ethics prohibiting health care professionals from participating in any "disciplinary sanctions or other restrictive measures."[42] The Rule explicitly requires that health care

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[40] *See, e.g.*, ACLU OF ME., CHANGE IS POSSIBLE: A CASE STUDY OF SOLITARY CONFINEMENT REFORM IN MAINE (2013), https://www.aclu.org/report/change-possible-case-study-solitary-confinement-reform-maine [https://perma.cc/K3AY-LG58]; David Kidd, *'I'm Somewhere Bettering Myself': Prison Reform Unlike Any Other in America*, GOVERNING (Aug. 2018) https://www.governing.com/topics/public-justice-safety/gov-north-dakota-prison-criminal-justice-reform.html [https://perma.cc/CTU7-HM5R]; Rick Raemisch, *Why I Ended the Horror of Long-Term Solitary in Colorado's Prisons*, ACLU (Dec. 5, 2018, 4:30 PM), https://www.aclu.org/blog/prisoners-rights/solitary-confinement/why-i-ended-horror-long-term-solitary-colorados-prisons [https://perma.cc/TBG5-MHMS].

[41] Many healthcare providers and medical and mental health professional groups consider solitary confinement conditions to be cruel, inhuman, and degrading treatment. *See, e.g.*, *Solitary Confinement (Isolation)*, NAT'L COMM'N ON CORRECTIONAL HEALTHCARE (Apr. 10, 2016), http://www.ncchc.org/solitary-confinement [https://perma.cc/SGV8-SE3F] [hereinafter *Solitary Confinement Position Statement*]; *see also* sources cited *supra* notes 29–30.

[42] The principle of medical ethics, and its application to the prison environment, as set out in Rule 46 has been upheld by the World Medical Association, the World Health Organization, and others. *See, e.g.*, HUMAN RIGHTS CENTRE, UNIV. OF ESSEX & PENAL REFORM INT'L, ESSEX PAPER 3: INITIAL GUIDANCE ON THE INTERPRETATION AND IMPLEMENTATION OF THE UN NELSON MANDELA RULES 66–70, 96–97 (2016), https://rm.coe.int/16806f6f50 [https://perma.cc/79ZJ-8NBT]; Jean-Pierre Restellini & Romeo Restellini, *Prison-Specific Ethical and Clinical Problems*, *in* WHO REG'L OFFICE FOR EUR., PRISONS AND HEALTH 11, 11–16 (Stefan Enggist, Lars Møller, Gauden Galea & Caroline Udesen eds.,

professionals monitor and report all adverse physical or mental health effects associated with solitary confinement *and* advocate for their patients' relief when such harms arise.[43] Notably, Rule 46(3) also requires that prisons grant health care personnel the "authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner."[44] As such, the Nelson Mandela Rules clarify and codify the affirmative duty of health care professionals to advance solitary confinement reform in their daily practice, but stop short of explicitly prohibiting clinicians from providing care in such circumstances.

The affirmative duty of health care providers to oppose solitary confinement was endorsed by the United States' National Commission on Correctional Health Care (NCCHC) in April 2016. The NCCHC statement affirms the essential principles contained in Rule 46 of the Nelson Mandela Rules, deeming solitary confinement lasting longer than fifteen consecutive days "cruel, inhumane, and degrading treatment, and harmful to an individual's health."[45] It also provides clear guidelines for health care professionals working in solitary confinement settings. The NCCHC statement acknowledges that tensions and conflicts often arise in these settings between correctional mandates and the professional and ethical responsibilities of health care providers. However, the statement also takes the important step of providing a set of principles by which health care providers may resolve some of these potential ethical conflicts. For example, the NCCHC statement both affirms correctional health professionals' primary duty to the wellness of their patients and specifically prohibits health care professionals from participating in the *process by which a prisoner is placed in solitary confinement*. In particular, health care professionals are prohibited from opining on whether prisoners are sufficiently healthy to be placed or remain in such conditions.

2014); *WMA Statement on Solitary Confinement*, in 65 WORLD MED. J., Nov. 2019, at 39, 39–41, https://www.wma.net/wp-content/uploads/2019/12/wmj_3_2019_WEB.pdf [https://perma.cc/UAB4-J5F8].

[43] NELSON MANDELA RULES, *supra* note 2, at 14.

[44] *Id.*

[45] *Solitary Confinement Position Statement*, *supra* note 41; *see also* Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY & L. 104, 106 (2010). For a discussion of just one example of the complex ethical issues with which mental health and medical professionals are presented in these settings, see J. Wesley Boyd, *Force-Feeding Prisoners Is Wrong*, 17 AM. MED. ASS'N J. ETHICS 904, 905–07 (2015). For additional discussion of the complicated role of health care professionals in solitary confinement, see Cyrus Ahalt, Alex Rothman & Brie A. Williams, *Examining the Role of Healthcare Professionals in the Use of Solitary Confinement*, 359 BRITISH MED. J., Oct. 2017, at 1.

Similarly, the NCCHC principles call for clinicians to adhere to medical standards of patient respect and confidentiality in solitary confinement as elsewhere. They specifically require that medical examinations be conducted in the most private, least restrictive setting possible, without restraints and out of the presence of custody officials "unless there is a high risk of violence."[46] In addition, the NCCHC statement emphasizes that persons in solitary confinement "should have as much human contact as possible" *and* that health care professionals should "advocate with correctional officials to establish policies prohibiting the use of solitary confinement for juveniles and mentally ill individuals, and limiting its use to less than 15 days for all others."[47] Echoing the Nelson Mandela Rules, the statement calls on healthcare providers to be a force for solitary confinement reform in their institutions and implies that care should not be diminished in any way by the patient's housing or disciplinary status.

The central tension for healthcare professionals asked to care for patients in solitary confinement—does the provision of care to patients confined to solitary confinement itself enable the practice, thus amounting to participation in punishment, and/or constitute endorsement or support of a cruel, inhuman, and degrading treatment?—was not resolved at the Santa Cruz Summit despite considerable discussion and deliberation. However, participants affirmatively endorsed the principles and prescriptions for the provision of care as set out in Rule 46 of the Nelson Mandela Rules, the NCCHC Position Statement, and similar guidelines issued by comparable international organizations, including the following:

- It is a violation of the central medical ethic "to do no harm" for health care professionals to be involved in nonclinical decision-making processes and procedures, including to render an opinion on the ability or suitability of any individual to withstand exposure to solitary confinement.
- Health care professionals have an affirmative duty to A) conscientiously and effectively monitor patients in settings of isolation given the high likelihood of those settings to cause harm and B) to recommend relief from such settings when they observe evidence that such release will be a benefit to patient health.
- Medical professionals should not allow conditions of confinement to dictate any departure of patient care from community standards in the extent, setting, or nature of the care they provide; for example, so-called "cell front" contacts—the examination of a patient through cell

[46] *Solitary Confinement Position Statement*, *supra* note 41.
[47] *Id.*

bars—do not substitute for actual medical or psychological evaluations that must take place in appropriate clinical settings without restraints unless there is an immediate risk of actual harm.

- Any psychological or physical health-related assessment of a person living in isolated confinement should include documentation of any and all observable or possible ill effects of solitary confinement on that person's health status.

In addition, the Santa Cruz Summit participants also agreed that correctional systems that use solitary confinement have a responsibility to educate health and correctional staff about the risks and harms commonly associated with prolonged and/or indefinite isolation. This includes how to assess changes in behavior or appearance that may indicate an imminent or ongoing physical or mental health concern and/or decompensation. Fundamentally, health care providers should always be accountable to health institutions and medical boards. The fact that in some systems, such as in the United States, accountability is primarily to the correctional authority and only secondarily to outside health organizations is problematic. Summit participants were not uniformly reassured by existing efforts by policymakers to ensure proper accountability, by correctional leadership to educate staff, or by staff to provide adequate care to persons held in solitary confinement. Their inability to reach consensus on the fundamental question of whether ethical care can be provided at all in the context of solitary confinement itself suggests an urgent need to dramatically scale back this practice.

Guiding Principle 6. Meaningful forms of external and internal monitoring and oversight are essential to buttress and advance solitary confinement reform and should aid in reducing the considerable variation in policy and practice that exists between different correctional systems. External monitoring and oversight are critical components of the process by which prison systems significantly reduce their use of solitary confinement. Oversight bodies, processes, and enforcement mechanisms are essential to ensure accountability, identify violations of the aforementioned principles, and correct instances where correctional or clinical practice falls below minimum standards. They can also assist in the dissemination of best practices across jurisdictions and establish common compliance standards. The Santa Cruz Summit's international participants emphasized that monitoring and oversight must be long-term and multilayered. For example, the European Union model includes comprehensive monitoring visits every four to five years by an international

agency—the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) is specifically tasked with identifying and eliminating aberrant, problematic prison practices within the forty-seven European member states. Additional and more frequent monitoring and national oversight is done by an independent government ombudsman or nongovernmental organizational and, in some instances, even more regular local oversight occurs. For example, in Scotland, volunteer laypeople from local communities visit prisons to observe and, when necessary, report on troubling conditions of confinement or correctional practices.[48]

Guiding Principle 7. As more prison systems significantly limit or eliminate solitary confinement, it is important that stakeholders document and disseminate evidence about the impact of these reforms, including that well-designed, properly implemented changes can reduce harm to incarcerated persons and correctional staff alike and, in many cases, enhance safety and security inside correctional facilities and for the public at large. Much of the apprehension over limiting the use of solitary confinement is rooted in concerns that greatly restricting or eliminating the practice will leave correctional staff and prisoners vulnerable to violence and mistreatment, and that correctional facilities may become chaotic and ungovernable. Yet, in jurisdictions where solitary confinement has been substantially reduced, the evidence to date is that the opposite has occurred. The emerging evidence is that solitary confinement reform benefits persons who both live and work in correctional environments, including correctional staff. In Maine, for example, workman's compensation claims declined from $200,000 to $40,000 in the span of two years following a rapid and significant reduction in the use of solitary confinement at the state's primary maximum security prison.[49] Staff assaults also significantly decreased, as did incidents of prisoner self-harm, which are often traumatic

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[48] DAVID STRANG, HM INSPECTORATE OF PRISONS FOR SCOT., WHAT NEXT FOR PRISONS IN SCOTLAND? REFLECTIONS ON FIVE YEARS AS HM CHIEF INSPECTOR OF PRISONS FOR SCOTLAND (2018), https://www.prisonsinspectoratescotland.gov.uk/publications/what-next-prisons-scotland [https://perma.cc/C6X7-Q4JY]; *see also, e.g.*, ROSA RAFFAELLI, CITIZENS' RIGHTS & CONSTITUTIONAL AFFAIRS, EUROPEAN PARLIAMENT, PRISON CONDITIONS IN THE MEMBER STATES: SELECTED EUROPEAN STANDARDS AND BEST PRACTICES 2 (2017), https://www.europarl.europa.eu/RegData/etudes/BRIE/2017/583113/IPOL_BRI(2017)583113_EN.pdf [https://perma.cc/9N4K-VUXG].

[49] Maurice Chammah, *Stepping Down from Solitary Confinement*, ATLANTIC (Jan. 7, 2016), https://www.theatlantic.com/politics/archive/2016/01/solitary-confinement-reform/422565/ [https://perma.cc/B2C5-4M3D].

for staff responders as well. Trends in North Dakota and Colorado—two states that also dramatically reduced their use of solitary confinement—were comparable and, over time, staff morale notably improved.[50] As additional studies of the impact of solitary confinement reform are undertaken, it is important that the broad benefits of solitary confinement reform are well documented and that the documentation of these outcomes is disseminated as broadly as possible.

Guiding Principle 8. Because the overuse of solitary confinement typically reflects and is related to dysfunction that exists in the larger correctional systems in which it is deployed, its reform should be recognized as part of the broader movement to reform prisons generally and to end the overuse of incarceration and the policies and practices that give rise to it. Like mass incarceration generally, solitary confinement is an inherently dehumanizing practice. It is often unjustly or unnecessarily imposed and plagued by racial bias. Moreover, it is incompatible with the ostensible goals of imprisonment—achieving safer prisons and free-world communities and a healthier society.[51] Framing solitary confinement as a gratuitous increase in the punishment that is already legally imposed on lawbreakers (incarceration) and as a practice that is incompatible with what should be one of the primary goals of imprisonment (successfully reintegrating formerly incarcerated persons back into society) underscores the conceptual connection between these closely aligned reform movements. That is, the official proclamations and statements by scholars, practitioners, and advocates from the medical, correctional, political, labor, religious, human rights, public health, and public safety communities about the need to significantly limit, if not eliminate, the use of solitary confinement are consistent with the larger movement to address and reduce mass incarceration.[52] Both movements can and should proceed in tandem.

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[50] For a thoughtful discussion of the positive aftermaths of some of these successful reforms, see THE ASS'N OF STATE CORR. ADMR'S & THE LIMAN CTR. FOR PUB. INTEREST LAW AT YALE LAW SCH., WORKING TO LIMIT RESTRICTIVE HOUSING: EFFORTS IN FOUR JURISDICTIONS TO MAKE CHANGES 4, 8 (2018), https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_workingtolimit.pdf [https://perma.cc/FA3U-8SS4].

[51] *See, e.g.*, JOHN J. GIBBONS & NICHOLAS DE B. KATZENBACH, THE COMM'N ON SAFETY & ABUSE IN AMERICA'S PRISONS, CONFRONTING CONFINEMENT (2006), https://www.vera.org/downloads/Publications/confrontingconfinement/legacy_downloads/Confronting_Confinement.pdf [https://perma.cc/5TWC-8HWW]; NAT'L RESEARCH COUNCIL OF THE NAT'L ACADS., THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 320–333 (Jeremy Travis et al. eds., 2014).

[52] In the United States alone, in addition to those mentioned above, organizations recently issuing formal statements include: the American Academy of Child and Adolescent Psychiatry, *Solitary*

CONCLUSION

The Santa Cruz Summit on Solitary Confinement and Health consisted of a group of international, interdisciplinary experts on solitary confinement who convened to review the current state of knowledge pertaining to solitary confinement reform. Participants collaborated to develop and achieve consensus on eight guiding principles intended to advance reform efforts. The principles were based on widely accepted evidence that solitary confinement is a form of psychological and physical trauma that places prisoners at significant risk of serious psychological and medical harm. Solitary confinement also can have serious adverse effects on the correctional and clinical staff members who are charged with administering it. The practice achieves few, if any, legitimate penological purposes that cannot be accomplished through less harmful alternatives and is ultimately incompatible with correctional security and public safety goals.

In the first and core Summit consensus principle, participants reaffirmed the 2008 Istanbul Statement that solitary confinement represents a form of trauma that places the mental and physical health of those exposed to it at significant risk of harm. If it is used at all, it must be reserved for the most exceptional cases, only when absolutely necessary, and even then, for

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Confinement of Juvenile Offenders, *supra* note 29; the American Bar Association, AM. BAR ASS'N, RESOLUTION 108A (2018), https://www.americanbar.org/content/dam/aba/images/abanews/mym2018res/108a.pdf [https://perma.cc/NC2C-R5CY]; the American Psychiatric Association, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS, *supra* note 15; the American Psychological Association, Letter from Am. Psych. Ass'n to Senator Cory Booker (June 8, 2017) (supporting the Maintaining Dignity and Eliminating Unnecessary Restrictive Confinement of Youths (MERCY) Act of 2017); the American Public Health Association, *Solitary Confinement as a Public Health Issue*, *supra* note 29; Mental Health America, *Position Statement 56: Mental Health Treatment in Correctional Facilities*, MENTAL HEALTH AM. (Mar. 7, 2015), https://www.mhanational.org/issues/position-statement-56-mental-health-treatment-correctional-facilities [https://perma.cc/BY2G-GSGL]; the National Alliance on Mental Illness, NAT'L ALL. ON MENTAL ILLNESS, PUBLIC POLICY PLATFORM 68 (rev'd 12th ed. 2016), https://www.nami.org/NAMI/media/NAMI-Media/downloads/Public-Policy-Platform_9-22-14.pdf [https://perma.cc/8KT9-W3YV]; the New York Bar Association, Letter from N.Y. City Bar to Members of the Bd. Of Corr. (Jan. 29, 2020), https://s3.amazonaws.com/documents.nycbar.org/files/2020641-RestrictiveHousinginCorrectionalFacilities_FINAL_1.29.20.pdf [https://perma.cc/M256-U68A]; the New York State Council of Churches, *Resolution Opposing the Use of Prolonged Solitary Confinement in the Correctional Facilities of New York State and New York City*, N.Y. ST. COUNCIL OF CHURCHES, (Sept. 2012), https://sites.google.com/site/nyscouncilofchurches/priorities/on-solitary-confinement [https://perma.cc/KL3Z-L47N]; the Rabbinical Assembly, *Resolution on Prison Conditions and Prisoner Isolation*, RABBINICAL ASSEMBLY (May 21, 2012), https://www.rabbinicalassembly.org/story/resolution-prison-conditions-and-prisoner-isolation [https://perma.cc/Y22Q-PJPV]; and the American College of Correctional Physicians (formerly the Society of Correctional Physicians), *Restricted Housing of Mentally Ill Inmates*, AM. C. OF CORRECTIONAL PHYSICIANS, http://accpmed.org/restricted_housing_of_mentally.php [https://perma.cc/4P9P-2BKP].

only the shortest amount of time possible. For certain groups of vulnerable prisoners, however, the risk of harm is too great to ever permit solitary confinement to be used. As the evidence of solitary confinement's physical and mental health consequences has grown over the past decade, the debate over whether the provision of health care to people in solitary confinement violates medical ethics has intensified. This highlights the growing consensus among health care professionals that solitary confinement should be greatly restricted or eliminated. In addition, concern for the well-being of all persons likely to be adversely affected by solitary confinement practices, including correctional and clinical staff members, provides additional justification for major reform efforts.

Looking ahead, Summit participants identified robust systems of external monitoring and oversight as essential to advance solitary confinement reform by enforcing minimum standards and identifying best practices. As more prison systems reduce their use of solitary confinement, these best practices—and the range of benefits they yield for incarcerated persons, correctional and clinical staff members, and the public at large—must be well documented and widely disseminated to accelerate reform. Finally, Summit participants acknowledged the urgency of the need for solitary confinement reform and its relationship to the broader movement and mission to end mass incarceration.

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