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Regulating the Use of Solitary Confinement in US Prisons

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Statement of Significance

This article aims to summarize relevant literature on the topic of prolonged solitary confinement from the perspective of the medical sciences to outline the detrimental health impacts associated with this practice, evaluate the extent to which the current use of this practice in the United States (US) aligns with the recommendations outlined in human rights literature, and offer recommendations to further regulate the use of solitary confinement in prisons to better align with the rehabilitative goals of the US criminal justice system.

This review details the well-studied physical and psychological harms associated with prolonged solitary confinement to support the notion that restrictions should be placed on the use of this practice for the well-being of incarcerated individuals. Additionally, it reviews the recommendations for appropriate use of this practice outlined in human rights literature and examines how the contemporary utilization of solitary confinement within US prisons fails to meet these proposed standards. Finally, this article offers specific recommendations regarding the appropriate settings in which solitary confinement should be used, key regulations to limit the extent of its use, and additional measures to minimize harm to incarcerated individuals.

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Solitary confinement is defined as the practice of housing individuals "with minimal to rare meaningful contact" with others.[9] Within the context of incarceration, solitary confinement is often practiced as the segregation of incarcerated individuals from the general prison population, often in restrictive housing units.[3,9] Restrictive housing units are specialized areas built to isolate select individuals for punity or safety and often include "sensory deprivation," limited time for "recreation and hygiene," and reduced access to "education, vocational, or rehabilitative programs."[3,9]

Historically, individuals have been placed in restrictive housing to enforce adherence to prison rules, provide "clinical or therapeutic" care to incarcerated persons, and to protect the safety of prison occupants and staff.[9] However, contemporary debates increasingly call the appropriateness of this practice into question. As solitary confinement is primarily exercised as a punitive measure, does it contribute to the supposed rehabilitative goals of the prison system? Myriad investigations into the detrimental impact of isolation within prisons, along with the rising utilization of solitary confinement within US prisons over the past 30 years, has spurred interest in evaluating how to reform this practice for the well-being of incarcerated individuals.[3,9]

The practice of solitary confinement in United States (US) prisons is commonplace at present: an estimated 1.9-4.4% of prison populations are detained in restrictive housing at any given point and roughly 18-20% of incarcerated individuals are exposed to solitary confinement over the course of a year.[1,29] Survey data from the Bureau of Justice Statistics also estimates that 9.5% of incarcerated individuals will spend more than 30 days in solitary confinement over a 12-month period.[1] Further, a 2019 survey from the Correctional Leaders Association and Arthur Liman Center for Public Interest Law at Yale Law School found that 81.4%

of 27,084 prison occupants in restrictive housing over 33 jurisdictions were detained in these units for greater than 30 days and 25.5% of these individuals had been isolated for over a year.[29]

This article aims to (1) classify prolonged solitary confinement as a human rights violation based on widely accepted criteria within human rights literature, (2) outline the detrimental health consequences of extended use of this practice, (3) examine its current use in the US, (4) assess its effectiveness as a form of punishment, (5) highlight the justification for its unregulated use in US prisons, and (6) offer recommendations for reforming current practices to minimize harm to incarcerated individuals.

Prolonged Solitary Confinement as a Human Rights Violation

Human rights documents from intergovernmental organizations classify the extended use of solitary confinement as a violation of the rights of incarcerated individuals. Article 5 of the Universal Declaration of Human Rights affirms that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[18] The United Nations expanded on the practices that constitute inappropriate treatment of incarcerated persons in the United Nations Standard Minimum Rules for the Treatment of Prisoners, colloquially known as the Mandela Rules. These rules were initially adopted in 1955, but were most recently updated in 2015 after the United Nations General Assembly requested that the Commission on Crime Prevention and Criminal Justice propose updates to these rules to reflect advances in the field of correctional science.[2] This process involved convening a group of subject matter experts, including "practitioners, administrators, researchers, service providers, and advocates," in collaborative conferences known as the *Essex Meetings*, to exchange information and provide evidence-based recommendations in a series of documents called the "Essex Papers."[25] These papers contributed substantially to the revisions that were ultimately accepted into the current version of the Mandela Rules.[25]

These rules define solitary confinement as "confinement […] for 22 hours or more a day without meaningful human contact" and further describe prolonged solitary confinement as isolated detention "in excess of 15 consecutive days."[27] Rule 43 of the Mandela Rules classifies indefinite or prolonged solitary confinement as a form of torture.[27] Further, in 2014, the UNC School of Law aggregated testimonies from incarcerated individuals, reports from mental health and criminology experts, and findings from national advocacy organizations to support the notion that the practices of solitary confinement meet criteria for torture and produced a report to affirm these findings.[11] Rule 45 of the Mandela Rules recommends that solitary confinement "be used only in exceptional cases as a last resort, for as short a time as possible," and be "prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures."[27] These recommendations were developed in response to evidence of the physical and psychological harms of prolonged use of this practice, which are discussed further below.

Health Impacts of Prolonged Solitary Confinement

The negative health impacts of prolonged solitary confinement are well-studied and can be stratified into psychological and physical harms. The evidence for psychological harm is more robust, as prolonged isolation from human contact in prisons was shown to be associated with the development of depression, negative attitudes, emotional dysregulation, psychotic illness, abnormal sleep cycles, panic disorders, post-traumatic stress disorder, and increased risk of suicidal ideation and completion, among others.[6,15,17]

Other data suggest associations between prolonged isolation in restrictive housing and the inability to organize one's life around a meaningful purpose and establish social relationships post-isolation.[10] These psychological disturbances have been shown to persist after reintroduction to the general prison population and subsequently after release from prison into the community.[6,15]

The evidence of physical harm from solitary confinement is less comprehensive, but this practice has been associated with increased risk of developing chronic illness. Confinement and restricted activity may result in physical deconditioning, chronic headaches, diaphoresis, tremulousness, palpitations, sleep disturbances, appetite changes, weight loss, abdominal pain, and fatigue.[15,17] As a result of chronic stress and the inability to engage in physical activity, isolated individuals may be more likely to develop hypertension, cardiovascular disease, and diabetes.[17]
Finally, data on post-incarceration mortality in North Carolina demonstrate individuals detained in restrictive housing units during their incarceration had an increased likelihood of mortality within one year of release from prison (24% more likely), when compared to that of individuals without exposure to these isolative units.[6] The major contributors to this mortality difference were increased rates of suicide within a year of release (78% more likely), death by homicide within one year of release (54% more likely), and opioid overdose death within two weeks of release (127% more likely).[6] The covariates accounted for in this retrospective cohort trial included "age, number of prior incarcerations, type of conviction, mental health treatment recommended or received, number of days served in the most recent sentence, sex, and race."[6]

In summary, the myriad detrimental psychological and physical impacts associated with prolonged solitary confinement warrant discussion of the appropriate use of this practice to minimize the long-term impact of these harms on the health of incarcerated individuals.

Use of Solitary Confinement in the United States and Current Legislation

There is currently no federal legislation limiting the use of solitary confinement in adults. Federal legislation mandates "annual reporting of prisoners who have been placed in solitary confinement at any time during the previous year" and restricts solitary confinement in juveniles solely to a "temporary response to the juvenile's behavior that poses a serious and immediate risk of physical harm to any individual" (provisions of the *First Step Act of 2018*).[23] A new federal law to limit the use of solitary confinement in accordance with the recommendations set forth by the Mandela Rules has recently been referred to a Congressional subcommittee.[4]

State law on the regulation of solitary confinement is widely variable, with the majority of states lacking any limitations on its use. Nine states (Arkansas, Georgia, Maryland, Massachusetts, Minnesota, Montana, New Jersey, New York, and Texas) have implemented legislation imposing limits on restrictive housing to some degree.[23,26] The legislation in Arkansas, Georgia, Maryland, and Texas apply solely to specific populations of incarcerated individuals, including pregnant women and individuals aged under 18 or 21 years.[23] In addition, seven states (Illinois, Maryland, Massachusetts, Michigan, Minnesota, New Mexico, and Virginia) have legislation mandating data collection and reporting on restrictive housing units.[23]

New Jersey and New York are the only states that imposes a limit on the number of consecutive days—20 and 15, respectively—and number of total days in a 60-day period—30 and 20, respectively—that can be spent in solitary confinement.[23,26] Other states simply require notification and review for stays exceeding 30 days.[23] Various

provisions present in the legislation from the aforementioned states limit the use of restrictive housing in incarcerated persons with disabilities, those with mental health disorders, pregnant individuals, and "on the basis of LGBTQ identification," among others. Additional requirements mandate minimum amounts of outside-cell time, mental health screenings and evaluations, minimum appropriate standards of holding facilities, treatment for physical and psychiatric harm, and a period of time prior to release from prison during which solitary confinement is prohibited.

Despite the legislation enacted in these aforementioned states, the majority of states still do not regulate the practice, and the absence of a federal mandate on federal or state prisons makes the use of solitary confinement largely unregulated in the US as a whole.

Effectiveness and Cost of Solitary Confinement

There is somewhat limited research into the effectiveness of solitary confinement as a punishment within US prisons. Briggs et al examined the ability for 'super-max' prisons— maximum-level security facilities with long-term solitary confinement for the most dangerous individuals—to minimize instances of in-prison violence and to improve prison staff safety.[21] This study found that opening super-max prisons had no significant impact on either measure of violence and concluded that the use of these facilities did not justify the substantial costs to operate them. Morris examined the incidence of future violent behavior in incarcerated individuals that committed acts of violence and were exposed to short-term solitary confinement, versus those who engaged in violent misconduct and were not punished with solitary confinement.[8] This study found that exposure to short-term solitary confinement does not result in an appreciable increase or decrease in the likelihood of future misconduct. Finally, a review examining the use of solitary confinement as a measure to reduce the misconduct of individuals in the future also demonstrated that exposure to and duration spent in solitary confinement was not associated with changes in the "prevalence or incidence of violent, non-violent, or drug misconduct in prison."[30] This suggests that while solitary confinement prevents the imminent threat of injury from a violent individual by isolating them from contact with others, its use as a tool to prevent future misconduct is not supported by evidence.

Additionally, in assessing the usefulness of this practice, it is important to compare its use in the US to that of other countries. Several European countries—including Finland, Sweden, Norway, and the Netherlands—have adopted provisions conforming to the recommendations outlined in the Mandela Rules, with restrictions on the utilization of solitary confinement by duration and criteria for use.[17] Despite significant restraints on the use of this form of punishment, many European countries have much lower recidivism rates and lower rates of in-prison violence.[7,17] However, the higher rates of violent crime in the US, as compared to many European countries, should be considered in evaluating whether a strategy to limit the use of solitary confinement would be similarly effective in US prisons. The comparatively poorer living conditions in US prisons, when compared to their European counterparts, have been attributed to higher rates of in-prison violence.[7] This suggests reforms in the structure and operation of the US prison system can reduce the widespread use of confinement as a punitive tool by reducing the overall incidence of violent behavior in prisons.

Finally, in assessing utility of solitary confinement as a mechanism for improving safety and well-being in prisons, cost should be considered to compare this practice appropriately to alternative interventions that can be implemented. Data suggests that the cost of detaining an individual

in solitary confinement can be up to three times the cost of detaining a person in the general population, as a result of the higher staffing requirement for observation and transport of patients in restrictive housing.[20,28] Further, "supermax" prisons are institutions built to house the entire prison population in isolation from one another, which require substantial capital to construct and operate. Data suggest that it costs up to an additional $30,000 annually to house an individual in restrictive housing, and that federal "supermax" facility operation costs 153% more than standard maximum-security prisons.[20] Finally, reducing the number of individuals in restrictive housing units in Mississippi, Illinois, and Colorado resulted in annual budgetary savings of $8-26 million in each state.[20]

Ultimately the limited evidence as to whether unregulated use of solitary confinement improves prison safety, along with the substantial costs of this practice, makes it difficult to argue that the current degree of utilization is necessary and effective at achieving its alleged goals. However, multiple stakeholders from within the prison system disagree with the notion of imposing restrictions on its use, given its purported utility. These counterarguments are discussed further below.

Arguments Against Restricting Use in the United States

Evidence supporting of the use of solitary confinement is largely anecdotal, from prison administrators, and based on what could be considered 'common sense' reasoning. In the process of identifying research evidence to support the use of this practice, a 2013 report from the Government Accountability Office found that the Federal Bureau of Prisons has never assessed whether the practice contributed to the safety of prison populations or prison staff.[12]

The most common justification for the continued use of solitary confinement is its utility in protecting incarcerated individuals from violent acts and ensuring staff safety from particularly dangerous occupants.[16] In addition, others argue the increased prevalence of gang activities in prisons makes the practice a useful tool to combat gang activity and prevent gang violence in prisons.[22] While there is no research evidence to support these claims, the limited research evidence to suggest otherwise makes it difficult to dispute them, as the logic behind them appears sound, even if possibly specious.

Another common argument against restricting the use of solitary confinement is denial that its utilization is as widespread and problematic as described in the literature. For example, in 2016, New Jersey Governor Chris Christie vetoed the passage of a bill that would restrict the use of solitary confinement in prisons, such that they followed the guidelines in the Mandela Rules.[13] Governor Christie claimed New Jersey prisons did not use solitary confinement— referring to the practice as "administrative segregation" instead— and criticized the passage of the bill as being politically motivated, despite conflicting evidence presented by New Jersey legislators.

Examination of Alternative Models and Potential Reforms

While the harms of long-term solitary confinement have been discussed, the argument that the practice be prohibited altogether is beyond the scope of this paper. The Mandela Rules concede the practice is permissible under specific circumstances, so long as limitations on its use are in place and it is utilized only in situations of necessity.[27] European models of rehabilitation in prisons report significantly better outcomes on recidivism, prison safety, and well-being of prison occupants; these models serve to demonstrate that restricting the use of this practice does not

necessarily compromise prison safety, so long as other structural alternatives are in place to mitigate these issues.[7,17,30] Therefore, this paper recommends that the US restrict the use of this practice to the guidelines outlined in the Mandela Rules and modify the environment of prisons to better match models of other high-income countries in order to improve the overall health and well-being of incarcerated individuals.

As alluded to earlier, the Restricting the Use of Solitary Confinement Act was introduced to the US House of Representatives on January 4th 2021, was referred to the Subcommittee on Crime, Terrorism, and Homeland Security on March 4th 2021, and is awaiting further action.[4] This act would seek to impose limitations on the use of solitary confinement in federal prisons by (1) limiting its use to a period of no more than 15 consecutive days or 20 days over a 60-day period, (2) further constraining its use in vulnerable populations and within a certain period prior to release, (3) enforcing continuous review of all individuals in confinement, (4) restricting its use to a limited subset of circumstances, (5) requiring a comprehensive medical and mental health exam by a physician, and (6) developing mechanisms for the incarcerated individual to contest this placement via an administrative review process.[4] State legislators also have a number of other bills in committee with the intent of imposing similar restrictions.

In addition to legislative changes, some individual prisons are experimenting with alternative detainment models to reduce the necessity of solitary confinement. In 2013, the New York City prison system experimented with a comprehensive new program called the Clinical Alternative to Punitive Segregation (CAPS) for incarcerated individuals with serious mental illnesses.[19] These units provided "therapeutic activities and interventions, […] individual and group therapy, art therapy, medication counseling, and community meetings" as an alternative to restrictive housing units. Individuals in the CAPS program subsequently had reduced rates of self-harm and injury, as compared to those in restrictive housing. The major caveat to the implementation of this program is expense, costing roughly $1.5 million annually to house up to 30 individuals. Other lower-security prisons in the US have begun to experiment with more open prison models resembling those in Europe, to attempt to refocus the goals of incarceration from retribution to rehabilitation.[7] These prisons have modified the structure of prisons away from the penal model—which relies on the presence of armed guards, concrete walls, and barred cells—towards a healthier built environment that more closely resembles a non-institutionalized living space.[7]

Research evaluating German prison systems demonstrate rehabilitative programs in open-prison settings improved the ability of incarcerated individuals to successfully re-integrate into society and find meaning in their incarceration after release, when compared to individuals in closed-prisons.[10] Findings from Norway also demonstrate lower recidivism rates and higher rates of post-incarceration employment than those in the US, as a result of their open-prison models.[5] However, these comparisons should be interpreted with caution, given differences in the cultural contexts in which these institutions are based.

Key Recommendations

In summary, solitary confinement is a form of punishment widely used in the US prison system with minimal restriction. Prison administrators often cite the necessity of the practice to deter in-prison violence and improve overall safety, though there is no definitive evidence to suggest that the long-term use of this practice positively or negatively impacts safety within prisons. Though the use of this practice may represent a requisite measure in protecting the welfare of prison occupants,

the long term psychological and physiological impacts of this practice merit a discussion on when and how solitary confinement is best utilized. Further, prison models in Europe with more successful measures of rehabilitation conform to the restrictions suggested by the Mandela Rules for restricting this practice, yet still demonstrate better overall safety than US prisons. As a result, the structure of US correctional facilities should be modified, and regulations on the use of solitary confinement should be implemented to minimize the health impact of incarceration and to avoid infringing on the rights of incarcerated individuals. A summarized list of recommendations from government, research, and nonprofit authorities are as follows:

1. Solitary confinement must only be used in situations related to violent conduct, where detention is necessary to isolate a violent individual from others or to protect an individual from violence. The prison should identify other means of punishing non-violent behavioral offenses that do not impose a serious health risk.[14,17,24]
2. Solitary confinement should be limited to the briefest amount of time possible to achieve the relevant punitive or safety goals. This time period should not exceed a period of 15 consecutive days or 20 total days over a 60-day period. Individuals should also be detained in the least restrictive setting necessary to ensure safety of all parties.8,10,30
3. Solitary confinement should be regulated more stringently in the case of vulnerable populations within the prison. These include juveniles, pregnant women, and individuals that are psychologically or physically incapable of tolerating such isolation.[14,17]
4. Prisons should consistently (1) document and review all individuals in solitary confinement, (2) collect data to establish performance indicators for the use of segregation, (3) periodically reaffirm the necessity of this punishment for all individuals in isolation, (4) provide mental and medical health assessments, and (5) develop plans for reintroduction into the general prison population. Reintroduction into the general prison population should include transitional 'step-down' units, where individuals are gradually reintroduced to more social interaction over a period of several days, to better prepare them for this transition.[14,17]
5. Prisons should improve conditions within the restrictive housing space to allow for adequate out-of-cell time, meaningful social interaction, counseling services, and educational opportunities. They should ensure that individuals in protective custody have the same privileges as members of the general prison population.[14,24]
6. Prisons should ensure that staff have appropriate education and training in effective communication, de-escalation of violent situations, and policies guiding the use of restrictive housing.[14,24]
7. Prisons should partner with legislators, nonprofit criminal justice organizations, and academic institutions to identify potential changes to the built environment of prisons to reduce the incidence of violence, promote the well-being of incarcerated individuals, and minimize the necessity for punitive correction measures.[7,14,24]

Implementation of these guidelines to modify current practices in the US prison system can lead to substantial gains in promoting the overall well-being of prison populations. This largely relies on a shift in ideology away from punishment of incarcerated persons towards a system of rehabilitation. Upholding the rights of these individuals is integral to the success of the US criminal justice system and its goals, while minimizing the health consequences of institutionalization on incarcerated persons.

Limitations

There are a few key limitations to this article. First, the process of identifying articles for reference did not include a systematic review of all relevant literature with a detailed set of inclusion and exclusion criteria. As a result, there may be additional articles present in the literature that relate to the arguments presented in this paper, but were not included for consideration. This article was intended to be a summary of the literature on solitary confinement as it pertains to the topics of health and human rights, rather than an exhaustive review of all relevant literature. Thus, a systematic review of this topic was considered beyond the intended scope of this paper.

Second, the scope of this article was narrowed to include a discussion on the appropriate use of solitary confinement in the US criminal justice system, and chose to exclude the separate discussion of the moral permissibility of solitary confinement as a whole. This latter argument would require a broader discussion and consideration of additional perspectives, such as those from proponents of prison abolition. Therefore, the argument about the acceptability of solitary confinement as a whole was considered beyond the intended scope of this article.

Finally, the recommendations outlined at the end of this article were created in part through examination of the criminal justice systems of other high-income countries. As noted in the article, there are differences between the US and these other countries with respect to the underlying cultural context within which these criminal justice systems are based. Therefore, caution should be exercised when making direct comparisons between these systems.

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