

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

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_limn_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

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

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/wpp1_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

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

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

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-SHURreport.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

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

<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>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.</p>
<p>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.</p>

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

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

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

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

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

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

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.prisoninspectoratescotland.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://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.

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_limam_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

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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