

# Solitary Confinement and Health

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Individuals released from prison experience a higher risk of death compared to non-incarcerated individuals [1, 2]. The transition back into the community post-release is characterized by instability related to social and economic factors that contribute to poor access to housing, employment, and health care [3, 4]. While this connection between incarceration and death has been demonstrated, little is known about the effect of specific conditions of confinement on mortality. One specific condition of confinement that is known to affect health is solitary confinement.

Solitary confinement—also sometimes referred to as restrictive housing or segregation—is widely used by both prisons and jails. Prisons use solitary confinement for both disciplinary purposes when someone breaks a rule and administrative purposes to isolate an individual who is at risk of victimization or violence. Individuals in solitary confinement are isolated in single cells for 22-24 hours daily and have limited access to privileges available to others (eg, visitation and participation in certain programs). Previous research has shown that solitary confinement leads to social isolation, sensory deprivation, and idleness. Furthermore, individuals with mental illness are over-represented in solitary confinement and are even more susceptible to psychological deterioration when isolated

[5, 6, 7]. A recent study among individuals incarcerated in the North Carolina prison system demonstrated that any time spent in solitary confinement was associated with an increased risk of all-cause mortality in the first year after release [8].

In response to public debate and the evidence that solitary confinement is harmful, the United Nations in 2015 revised the Standard Minimum Rules on Treatment of Prisoners to establish the “Mandela Rules,” which call for an end to its prolonged use [9]. Specifically, these rules stipulate that using solitary confinement for more than 14 consecutive days constitutes torture according to international law. Brinkley-Rubinstein and colleagues recently examined whether there were disparate harms associated with long-term (>14 days) versus short-term (<14 days) solitary confinement and found that those who experienced multiple, distinct experiences and extended periods of solitary confinement (>14 days) had increased risk of re-incarceration and death [8].

Given the harms that are associated with solitary confinement, correctional systems should explore alternatives and limit the number of days in restricted housing. The North Carolina Department of Public Safety (DPS) has launched initiatives, in partnership with the Vera Institute of Justice, to reduce the number of incarcerated

individuals who are placed in solitary confinement. For instance, two diversion units have been created: 1) the therapeutic diversion unit, which is an alternative to solitary confinement particularly for individuals with severe mental illness, and 2) rehabilitative diversion units that provide therapeutic services to individuals who have been in solitary confinement for extended periods of time (>30 days) with an aim to help them re-integrate into the general population. Those who are under 18 are now restricted from being put in solitary confinement.

More research is needed to more clearly understand the pathways via which solitary confinement negatively affects pre- and post-release health outcomes. Many states have recognized the possible harms solitary confinement can pose and have limited its use. For instance, a handful of states, including Colorado and New Jersey, have recently restricted the use of solitary confinement. In North Carolina, alternatives to solitary confinement have been implemented, but these programs too must be evaluated to understand their efficacy. Correctional systems that still utilize solitary confinement should limit its use to be compliant with the Mandela Rules, and at the very least consider solitary confinement as an indicator of risk to be considered during discharge planning.

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