Physicians for Human Rights

HIRC
HARVARD IMMIGRATION AND REFUGEE CLINICAL PROGRAM

PEELER Immigration Lab

"Endless Nightmare"

Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention

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Acknowledgments

Contents

This report was written jointly by students and faculty of the Harvard Immigration and Refugee Clinical Program (HIRCP) and Harvard Law School (HLS), members of the Peeler Immigration Lab (PIL) at Harvard Medical School (HMS), and Physicians for Human Rights (PHR).

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Cover: View through a peephole into a single cell at the police department.
Photo: Thomas Imo via Getty Images / Contributor

Executive Summary

The United States maintains the world's largest immigration detention system, detaining tens of thousands of people in a network of facilities, including those managed by private prison corporations, county jails, U.S. Immigration and Customs Enforcement (ICE), U.S. Customs and Border Protection (CBP), and the Office of Refugee Resettlement (ORR). At the time of writing, ICE is detaining over 35,000 people, including long-term residents of the United States, people seeking asylum, and survivors of trafficking or torture. **Instead of finding refuge, these people are held in ICE custody for extended periods, enduring inhuman conditions such as solitary confinement (dubbed "segregation" by ICE), where they are isolated in small cells with minimal contact with others for days, weeks, or even years. In many instances, such conditions would meet the definition of torture, or cruel, inhuman, or degrading treatment under international human rights law.**

Solitary confinement causes a range of adverse health effects, including post-traumatic stress disorder (PTSD), self-harm, and suicide risks. **Prolonged confinement can lead to lasting brain damage, hallucinations, confusion, disrupted sleep, and reduced cognitive function.** These effects persist beyond the confinement period, often resulting in enduring psychological and physical disabilities, especially for people with preexisting medical and mental health conditions or other vulnerabilities.

In recognition of this well-documented harm, ICE issued a directive in 2013 to limit the use of solitary confinement in its facilities, especially for people with vulnerabilities. A 2015 memorandum further protected transgender people, emphasizing solitary confinement as a last resort. In 2022, ICE reinforced reporting requirements for people with mental health conditions in solitary confinement, highlighting the need for strict oversight. Despite these directives, however, government audits and whistleblowers alike have repeatedly revealed stark failures in oversight.

This report – a joint effort by Physicians for Human Rights (PHR), Harvard Law School's Immigration and Refugee Clinical Program (HIRCP), and researchers at Harvard Medical School (HMS) – provides a detailed overview of how solitary confinement is being used by ICE across detention facilities in the United States, and its failure to adhere to its own policies, guidance, and directives. It is based on a comprehensive examination of data gathered from ICE and other agencies, including through Freedom of Information Act (FOIA) requests, first filed in 2017, and partly acquired after subsequent litigation. It is further enriched by interviews with 26 people who were formerly held in immigration facilities and experienced solitary confinement over the last 10 years.

The study reveals that immigration detention facilities fail to comply with ICE guidelines and directives regarding solitary confinement. Despite significant documented issues, including whistleblower alarms and supposed monitoring and oversight measures, there has been negligible progress. The report highlights a significant discrepancy between the 2020 campaign promise of U.S. President Joseph Biden to end solitary confinement and the ongoing practices observed in ICE detention. Over the last decade, the use of solitary confinement has persisted, and worse, the recent trend under the current administration reflects an increase in frequency and duration. Data from solitary confinement use in 2023 – though likely an underestimation as this report explains – demonstrates a marked increase in the instances of solitary confinement.

This report exposes a continuing trend of ICE using solitary confinement for punitive purposes rather than as a last resort – in violation of its own directives. **Many of the people interviewed were placed in solitary confinement for minor disciplinary infractions or as a form of retaliation for participating in hunger strikes or for submitting complaints. Many reported inadequate access to medical care, including mental health care, during their solitary confinement, which they said led to the exacerbation of existing conditions or the development of new ones, including symptoms consistent with depression, anxiety, and PTSD.** The conditions in solitary confinement were described as dehumanizing, with people experiencing harsh living conditions, limited access to communication and recreation, and verbal abuse or harassment from facility staff.

"ICE oversaw more than 14,000 placements in solitary confinement between 2018 and 2023. Many people who are detained in solitary confinement have preexisting mental health conditions and other vulnerabilities. The average duration of solitary confinement is approximately one month, and some immigrants spend over two years in solitary confinement."

Executive Summary

continued

Analysis of FOIA data revealed persistent and prolonged use of solitary confinement and demonstrated significant inadequacies of current oversight and accountability mechanisms. **In the last five years alone, ICE has placed people in solitary confinement over 14,000 times, with an average duration of 27 days, well exceeding the 15-day threshold that United Nations (UN) human rights experts have found constitutes torture. Many of the longest solitary confinement placements involved people with mental health conditions, indicating a failure to provide appropriate care for vulnerable populations more broadly.**

Some solitary confinement placements lasted significantly longer, with 682 lasting at least 90 days and 42 lasting over one year. Many of these instances involved people with mental health conditions and other vulnerabilities, with 10 placements lasting over a year in solitary confinement. **Data provided by ICE also demonstrated a disproportionately harmful impact on people with vulnerabilities, particularly transgender people and those with mental health and medical conditions.**

The treatment of people in immigration detention facilities and the excessive, punitive use of solitary confinement is not only contrary to ICE's own policies and guidance but also violates U.S. constitutional law and international human rights law. The Fifth Amendment prohibits the deprivation of life, liberty, or property without due process of law, protection that extends to all persons within the United States, including people in immigration detention. The government has a duty to ensure the health and safety of people in immigration detention facilities by providing for their basic needs such as food and medical care. Persons in detention also have First Amendment rights, including the freedom to protest conditions or report issues without fear of retaliation.

International human rights law has also made clear that the detention of immigrants, especially in solitary confinement, should be a last resort, for the shortest time possible, and used only for limited purposes. The United States has signed and ratified the International Covenant on Civil and Political Rights (ICCPR), which prohibits arbitrary and unlawful detention. The use of prolonged solitary confinement, especially for people with mental health conditions, is prohibited under the UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). The United States has also signed and ratified the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The UN Special Rapporteur on Torture has highlighted the severe psychological and physical harm caused by prolonged solitary confinement, especially for people with mental health conditions.

ICE's failure to adhere to domestic and international law and its own guidelines has created dangerous conditions in detention centers, particularly for people with mental and medical health conditions or other vulnerabilities. The persistent use of solitary confinement over the last decade underscores the need for radical changes in ICE policy and practice. **The evidence of profound physical and mental health deterioration caused by solitary confinement, in combination with ICE's inability to implement policies around its use that adhere to its own guidelines as well as constitutional and international law, necessitates an immediate commitment by ICE to end the practice entirely.** Prior to publication, the authors of this report had the opportunity to present the findings to key personnel in DHS and ICE.

Recommendations

The report makes the following recommendations to the Secretary of the U.S. Department of Homeland Security (DHS) and to the Director of ICE, which serve as a road map to completely phase out the use of solitary confinement in immigration detention. Full recommendations to other engaged actors can be found starting on p. 34.

1. **Publicly commit to ending the use of solitary confinement in all immigration detention facilities.** As it abandons solitary confinement, DHS and ICE must express this commitment in the form of a binding directive. The directive should:
   a. **Require a presumption of release from ICE detention for people who have reported existing vulnerabilities**, including, but not limited to, people with serious medical conditions, mental health conditions, disabilities, LGBTQIA+ people, and survivors of torture and/or sexual violence. These people should be released into the safety of their community with post-release care plans in place, per the 2022 ICE directive, in addition to providing resources and referrals for social, legal, and/or medical services as appropriate.
   b. **Mandate that any person in detention be afforded 24-hour access to qualified mental and medical health care professionals** who respond in a timely manner and in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
   c. **Require increased transparency from ICE's Detention Monitoring Council** by making properly redacted or deidentified reports and reviews related to solitary confinement publicly available on the agency's website within 72 hours of the order. to place someone in solitary confinement.

2. **Amend the 2013 "Segregation Directive" to ensure that every immigration detention facility, public or privately contracted, is required to report concurrently to ICE Field Office Directors and ICE headquarters within 24 hours of placing someone in solitary confinement.** ICE headquarters, in turn, must share this consolidated "segregation"/solitary confinement data with the DHS Office of the Secretary within 72 hours. This requirement must apply to every confined person, regardless of the duration of their confinement or whether they have a vulnerability. Additionally:
   a. For those who are currently in solitary confinement, require a prompt and meaningful psychosocial and medical evaluation, undertaken by qualified medical professionals, who can assess the prevalence and extent of existing vulnerabilities.
   b. For those scheduled for placement in solitary confinement, require a meaningful psychosocial and medical evaluation by qualified medical professionals who can assess the prevalence and extent of existing vulnerabilities prior to such a placement.
   c. Mandate the reporting of race and ethnicity of each person in solitary confinement.
   d. Mandate reporting of the justification provided for initial confinement; justification for continued confinement; duration of the confinement; any vulnerabilities identified; and a detailed description of the alternatives to solitary confinement that were considered and/or applied, as listed in 5.3.(2) of the 2013 "Segregation Directive."
   e. Require daily checks and regular monitoring and documentation by qualified and licensed health care professionals against a detailed checklist created in partnership with independent medical professionals, that includes reviewing vital signs, checking for signs of self-harm, and any other indicators of deteriorating mental and physical health.
   f. Require the routine sharing by ICE of deidentified data acquired from the above reporting mechanisms on its website every two weeks as part of its release of Detention Statistics, until it has ended the use of solitary confinement.

Recommendations

continued

3. **Revise current contracts and agreements with immigration detention facility providers and contractors to include stringent performance standards and clear metrics for compliance regarding the use of solitary confinement. Compliance should be assessed through regular and comprehensive inspections by the Contracting Officer.** Additionally, to increase adherence to detention standards, ICE must:
   a. Introduce a performance-based contracting model, where a portion of payment is contingent upon meeting certain performance and reporting indicators, including those listed in recommendations 1 and 2 herein; and
   b. Impose immediate financial penalties for any violation of performance and reporting indicators, and contract termination for repeated or persistent violation.

4. **Establish a task force led by the Office of the Secretary of DHS to develop a comprehensive plan including specific recommendations for phasing out the use of solitary confinement.** The task force must include:
   a. Members with knowledge of, or expertise regarding, the mental and physical health consequences of the use of solitary confinement;
   b. Independent medical experts;
   c. Independent subject matter experts from civil society (including those with expertise in the use of solitary confinement in criminal and civil custodial settings and human rights);
   d. Formerly detained immigrants who have experienced solitary confinement in ICE custody; and
   e. Employees of the following offices:
      I. Civil Rights and Civil Liberties (CRCL);
      II. ICE Health Services Corps (IHSC);
      III. Immigration Detention Ombudsman (OIDO);
      IV. Enforcement and Removal Operations (ERO); and
      V. Office of Professional Responsibility (OPR).

   The plan must be presented to Congress and publicly accessible on ICE's website upon completion, which shall be no later than one year after formation of the task force. Finally, recommendations included in the plan should ensure the end of ICE's use of solitary confinement in immigration detention within one year of presentation of the plan to Congress and the public.

Introduction

The United States operates the world's largest immigration detention regime. On any given day, tens of thousands of adults and children are detained in a vast network of facilities, including those operated by private prison corporations,[1] county sheriffs, U.S. Immigration and Customs Enforcement (ICE), U.S. Customs and Border Protection (CBP), and the Office of Refugee Resettlement (ORR). Immigration detention is legally considered civil rather than criminal custody, but many immigrants are held in correctional facilities, which means the conditions of confinement are often the same as criminal incarceration.

As of the writing of this report, ICE is currently detaining more than 35,000 people.[2] These include people who have built a life in the United States for decades as well as people who have recently arrived seeking asylum, including trafficking or torture survivors who fled their home countries for their own safety. Those hoping to find refuge in the United States are instead imprisoned, often for months or even years while they wait for their immigration applications to be resolved or to be deported. As they wait, they are frequently subjected to inhuman conditions, including, as this report details, the danger, indignity, and harm of solitary confinement – being held in small cells with little or no contact with other people for days, weeks, or even years at a time.[3]

Given the lack of oversight and transparency regarding the use of solitary confinement in immigration detention, Physicians for Human Rights (PHR), along with faculty and students at Harvard Law School (HLS) and Harvard Medical School (HMS), have sought to spotlight what is happening in the "black box" of solitary confinement in ICE detention centers. This report is the culmination of that work and reflects years of research to uncover how many people have been held in solitary confinement, the conditions in solitary confinement, the sense of helplessness felt by those subject to solitary confinement – sometimes for months or even years – and the harmful impact of solitary confinement on people after their release from detention.

Much of the data in this report was obtained by faculty and students at HLS through Freedom of Information Act (FOIA) requests and subsequent litigation that builds on records previously obtained by the Project on Government Oversight (POGO) and the International Consortium of Investigative Journalists (ICIJ). This report also draws on dozens of personal interviews with survivors of solitary confinement conducted by faculty and students at HMS. This report details the abusive and excessive use of solitary confinement in immigration detention. For example, ICE oversaw more than 14,000 placements in solitary confinement between 2018 and 2023. Many people who are detained in solitary confinement have preexisting mental health conditions and other vulnerabilities.[4] The average duration of solitary confinement is approximately one month, and some immigrants spend over two years in solitary confinement,[5] illustrating how concerns repeatedly raised by members of Congress, government auditors, and whistleblowers alike about the prolonged and excessive use of solitary confinement have been ignored.[6]

Background

Solitary Confinement in ICE Detention

Solitary confinement is generally defined as isolating someone in a cell for 22 hours or more per day without meaningful human contact.[7] However, ICE describes this practice euphemistically as "segregation" or "segregated housing," using it as both punishment (termed "disciplinary segregation") and ostensibly for safety ("administrative segregation").[8] In this report, the term "solitary confinement" will be consistently used, unless directly quoting ICE or other official government records where the term "segregation" was applied. Notably, the need for medical isolation when no "designated medical unit exists" is one stated purpose of administrative "segregation." However, this is in stark contrast to standard medical care of patients who need isolation for medical reasons. In the latter, isolation rooms are simply normal rooms with windows and regular furniture and bedding but the influx and egress of persons are controlled. Rooms are not locked, isolated persons do not lose most of their "privileges," and while confined, one is made to feel like a patient, not a prisoner.

The adverse health effects of solitary confinement are well-documented and include post-traumatic stress disorder (PTSD) and increased risks of self-harm and suicide.[9] According to research, isolation can cause lasting brain damage and trigger symptoms such as hallucinations, confusion, heart palpitations, disrupted sleep, and reduced cognitive function.[10] These symptoms can extend beyond the period of solitary confinement and affect people after their release by causing enduring psychological and physical disabilities and impairments.[11] For people with preexisting medical and mental health conditions, solitary confinement can worsen existing conditions and even lead to suicide.[12] Solitary confinement thus exacerbates the well-documented high rates of suicide of immigrants in ICE detention.[13]

International law clarifies that prolonged solitary confinement "can amount to torture or cruel, inhuman or degrading treatment or punishment when used as a punishment … for persons with mental disabilities or juveniles."[14] As such, in 2011 the UN Special Rapporteur on Torture called for an "absolute prohibition" on solitary confinement for more than 15 days.[15] Additionally, the Rapporteur recognized that shorter periods of solitary confinement for legitimate disciplinary reasons can constitute "cruel, inhuman or degrading treatment or punishment where the physical conditions of prison regime (sanitation, access to food and water) fail to respect the inherent dignity of the human person and cause severe mental and physical pain or suffering."[16]

ICE Directives on Solitary Confinement

2013 "Segregation Directive"
After years of documentation and advocacy by civil society, ICE issued a directive in 2013 – over a decade ago – that mandates limiting and monitoring the use of solitary confinement in immigration detention. The 2013 "Segregation Directive" describes two forms of solitary confinement: administrative segregation and disciplinary segregation.[17] Before someone can be placed in disciplinary segregation, the directive states that there must be a hearing and a finding by a disciplinary panel.[18]

According to the 2013 "Segregation Directive," administrative segregation is "a non-punitive form of separation from the general population" and is authorized "only as necessary to ensure the safety of the detainee, facility staff, the protection of property; or the security or good order of the facility."[19] Consequently, the directive warns that placement in solitary confinement "is a serious step that requires careful consideration of alternatives" before it is used.[20] For people with special vulnerabilities, such as those with mental health conditions, serious medical conditions, disabilities, LGBTQIA+ people, and torture, trafficking, and trauma survivors, the directive mandates that solitary confinement should be "only used as a last resort and when no other viable housing options exist."[21] Facilities must notify the ICE Field Office Director (FOD) if someone has a special vulnerability as soon as possible but not more than 72 hours after placement in solitary confinement, or when anyone has been placed in solitary confinement for 14 consecutive days or 14 days in a 21-day period.[22]

Special Protections for Vulnerable Populations

2015 Memorandum: Transgender People in Detention
In 2015, ICE issued a memorandum emphasizing the need for additional protections for transgender people in detention. Like the 2013 "Segregation Directive," the 2015 guidance emphasized that transgender people should be placed in solitary confinement only "as a last resort and when no other temporary housing option exists."[23] Under the guidance, if a facility cannot meet this requirement or if there are concerns about the conditions of confinement, ICE is required to examine whether transferring the person to a different facility is a viable option.[24]

2022 Directive: "Individuals with Serious Mental Illness"
In 2022, ICE issued a further directive related to detained persons with serious mental health conditions that reiterated the heightened reporting requirements when placing such persons in solitary confinement.[25] The directive further echoed the 2013 "Segregation Directive" by specifically mandating that facilities notify the ICE FOD and the ICE Office of the Principal Legal Advisor within 72 hours of placing any immigrant with a serious mental health condition in solitary confinement.[26]

ICE Solitary Confinement Oversight Mechanisms

The 2013 "Segregation Directive" requires FODs to collect data from facilities on their use of solitary confinement so that ICE headquarters can provide oversight. Specifically, immigration detention facility administrators are required to notify FODs within 72 hours of the use of solitary confinement on anyone who has medical or mental illness, has a special vulnerability and/or because the detained person is an alleged victim of sexual assault, is an identified suicide risk, or is on hunger strike.[27] The 2013 "Segregation Directive" also mandates reporting on the prolonged use of solitary confinement for any person with or without these vulnerabilities when they have been held "for 14 days, 30 days, and at every 30-day interval thereafter" or "for 14 days out of any 21 day period."[28]

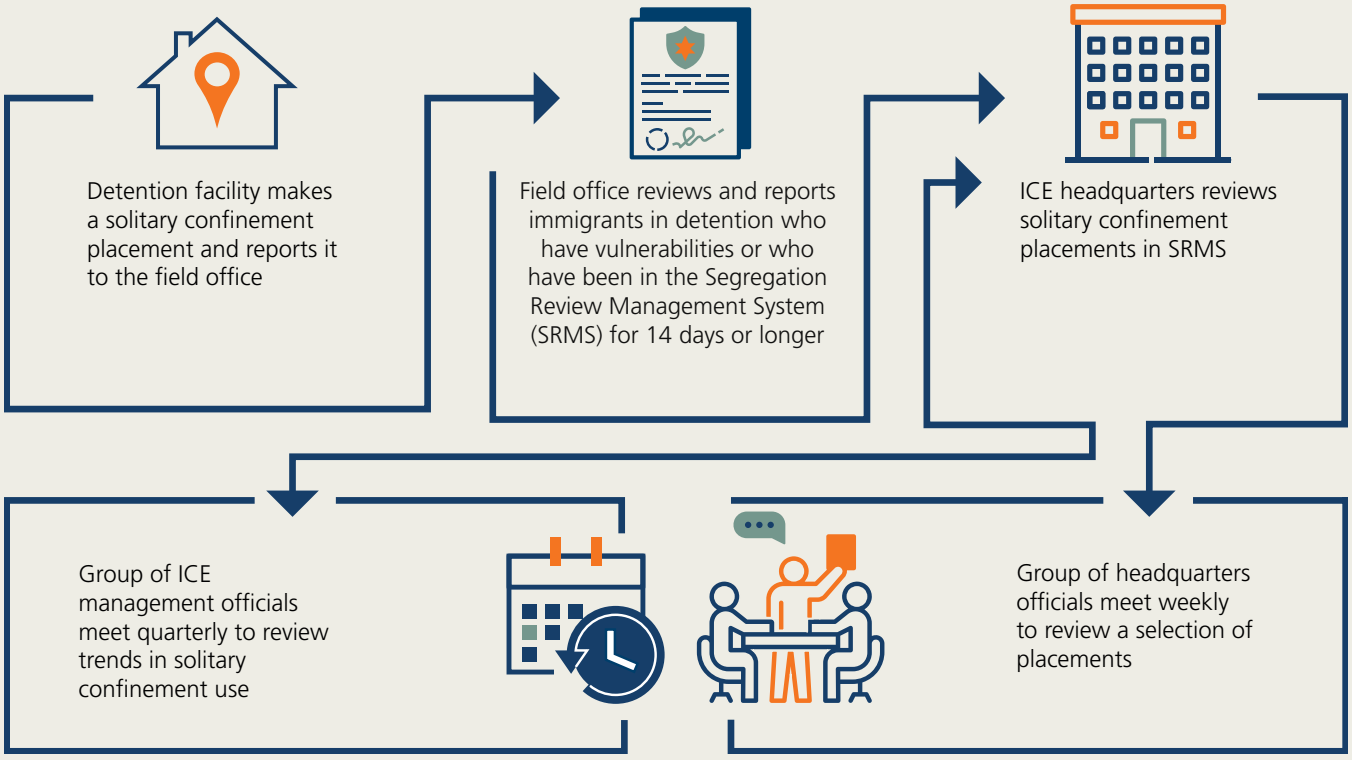
ICE's oversight mechanism for solitary confinement has been described in more detail by the U.S. Government Accountability Office (GAO) in a 2022 report.[29] Per the report, ICE headquarters staff within "Custody Management" conduct reviews of all solitary confinement placements in what is known as a "Segregation Review Management System" (SRMS).[30] The staff review compliance with ICE detention standards and directives. Representatives of a select group of ICE offices, including Custody Management, Office of the Principal Legal Advisor attorneys, and ICE Health Service Corps, also conduct weekly reviews for compliance with detention standards.[31]

ICE also maintains a "Detention Monitoring Council," comprised of management officials who meet quarterly to discuss overall detention-related issues, including solitary confinement. Headquarter officials from Custody Management present a report on solitary confinement statistics, which includes, among other things, length of solitary confinement, reasons for confinement, and how many individuals were considered members of vulnerable populations.[32]

In addition to oversight through the mechanisms described above, solitary confinement practices are also monitored through facility inspections and onsite monitoring of detention standards compliance, including by independent inspectors, and by the DHS Office of Inspector General (OIG).[33]

A process map of ICE's oversight mechanism for solitary confinement, as described in the GAO report, can be seen in Graphic 1, below.[34]

Graphic 1: ICE Solitary Confinement Oversight Mechanism Process Map



Documentation of Noncompliance and Abuse

Despite these directives, whistleblowers and government investigators alike have documented the abuse and overuse of solitary confinement in immigration detention over the past decade, particularly among vulnerable groups such as people with mental health conditions, physical disabilities, LGBTQIA+ people, and survivors of torture and domestic violence.[35] Oversight mechanisms have also been repeatedly flagged as failing to ensure compliance.[36] Indeed, current Homeland Security Secretary Alejandro Mayorkas has been on notice about these failures related to solitary confinement since 2014.[37] The OIG, which provides independent oversight of DHS, has expressed concern about ICE's repeated failure to follow its own directives limiting the use of solitary confinement.[38] In a 2021 audit, OIG reiterated those concerns while flagging ongoing problems with complying with reporting requirements and record retention policies related to "segregation."[39] Recognizing that solitary confinement can result in severe negative psychological effects, particularly for people with preexisting mental health conditions or people at risk of suicide, OIG also concluded that ICE had failed to document whether it properly considered alternatives before placing someone in "segregation."[40]

Similarly, a 2022 report from the GAO again highlighted that ICE did not consider alternatives to "segregation" for most placements.[41]

"Between 2012 and 2014, experts submitted reports to DHS' Office of Civil Rights and Civil Liberties documenting deaths of people detained in solitary confinement … Over 10 years later, little has changed."

Recent Developments and Persistent Failures

In September 2023, the Department of Homeland Security's Office for Civil Rights and Civil Liberties (CRCL) and the DHS Office of General Counsel issued a memorandum documenting more than 60 complaints over the past four years regarding people with serious mental health conditions or a mental health disability held in solitary confinement in ICE custody across the country.[42] The seven examples provided in the memorandum reflected a range of issues, including immigrants held in solitary confinement while on suicide watch and with diagnoses such as chronic PTSD, major depressive disorder, bipolar disorder, and schizophrenia.[43] The memorandum also revealed that immigrants were reluctant to report suicidal ideation and mental health concerns because they feared being placed in solitary confinement.[44] According to the complaints, immigrants were often left without access to psychiatric medication, access to counsel or legal visits, or the ability to send or receive mail while in solitary confinement.[45]

These concerns are longstanding. In 2012, PHR, in partnership with the National Immigrant Justice Center, published a report on solitary confinement in ICE detention, "Invisible in Isolation: The Use of Segregation and Solitary Confinement in Immigration Detention."[46] That report demonstrated how solitary confinement of people in ICE custody was applied arbitrarily, inadequately monitored, harmful to health, and a violation of their due process rights.

Between 2012 and 2014, experts submitted reports to CRCL documenting deaths of people detained in solitary confinement, where the deceased had presented signs of mental illness, ranging from depression to schizophrenia. Despite having special vulnerabilities, they were nevertheless subjected to solitary confinement without consideration of more appropriate care or medication.[47]

Over 10 years later, little has changed. Recent complaints filed by advocates continue to highlight the arbitrary and excessive use of solitary confinement in immigration detention. In a Colorado facility, for example, advocates documented escalating misuse of solitary confinement, including its use as a retaliatory threat. One person was placed in solitary confinement more than 10 different times for reasons ranging from eating "too slowly" and speaking "too loudly" to having suicidal thoughts and being upset about deportation.[48]

Methodology and Limitations

A two-pronged approach guided the data collection for this report. First, faculty and students at HLS collected and analyzed data that they obtained from ICE and other federal agencies, including through litigation under FOIA. This data included reports, excel spreadsheets, e-mails, and other documents from ICE and other federal agencies concerning the use of solitary confinement in immigration detention. Second, HMS faculty and students conducted qualitative, structured interviews with formerly detained immigrants who had experienced solitary confinement. While the aim with the ICE data was to generate aggregate statistics on people detained in solitary confinement in facilities nationwide, the goal of the interviews was to explore personal experiences in confinement.

ICE FOIA Data Analysis

With some limited exceptions, FOIA requires federal agencies like ICE to disclose previously unpublished or unreleased information pursuant to public records requests. In November 2017, HIRCP submitted FOIA requests to several federal agencies, including ICE, to obtain previously unpublished communications, records, training materials, evaluation reports, and memorandums documenting ICE's use of solitary confinement in detention facilities.

After the agencies failed to adequately respond to these requests, HIRCP successfully sued ICE and other federal agencies in federal court. In July 2023, the U.S. District Court for the District of Massachusetts ordered ICE to respond to many of HIRCP's requests.[49] In October 2023 – six years after HLS filed its original FOIA requests – ICE finally produced records detailing its use and misuse of solitary confinement in immigration detention.

ICE uses the SRMS to track solitary confinement placements. HIRCP received a redacted SRMS spreadsheet from ICE detailing, among other things, the reasons for placing people in solitary confinement, the dates those people were placed in solitary confinement, the duration they were held in solitary confinement, and the names of facilities that placed people in solitary confinement.[50] The spreadsheet is similar to records obtained by POGO and ICIJ,[51] but the information obtained by HIRCP includes more recent data on solitary confinement placements with release dates between September 4, 2018 and September 13, 2023. This data came from 125 facilities throughout the United States that are run by or contract with ICE.[52]

HLS faculty and students analyzed the data using Microsoft Excel and Stata to determine the average length of time that people were held in solitary confinement as well as the total number of solitary confinement placements. Further analysis was conducted to compare this data across years and facilities. Additionally, HLS assessed some of the reasons listed for why immigrants were placed in solitary confinement. The code and data to reproduce these analyses are available online at Harvard Dataverse.

HLS faculty and students also reviewed several ICE quarterly reports as well as medical expert reports commissioned by CRCL that were produced in response to the FOIA litigation.[53] The medical expert reports focused on assessing mental health conditions of people detained, as well as assessing mental health resources at the Henderson Detention Center, Nevada; Etowah County Detention Center, Alabama; Clinton County Correctional Facility, Pennsylvania; and Houston Contract Detention Center, Texas.[54]

Despite the significant disclosures obtained through the FOIA process and litigation, several limitations restricted HIRCP's analysis. By the time of this report, ICE had still not released all the data the district court ordered it to produce.

Methodology and Limitations

continued

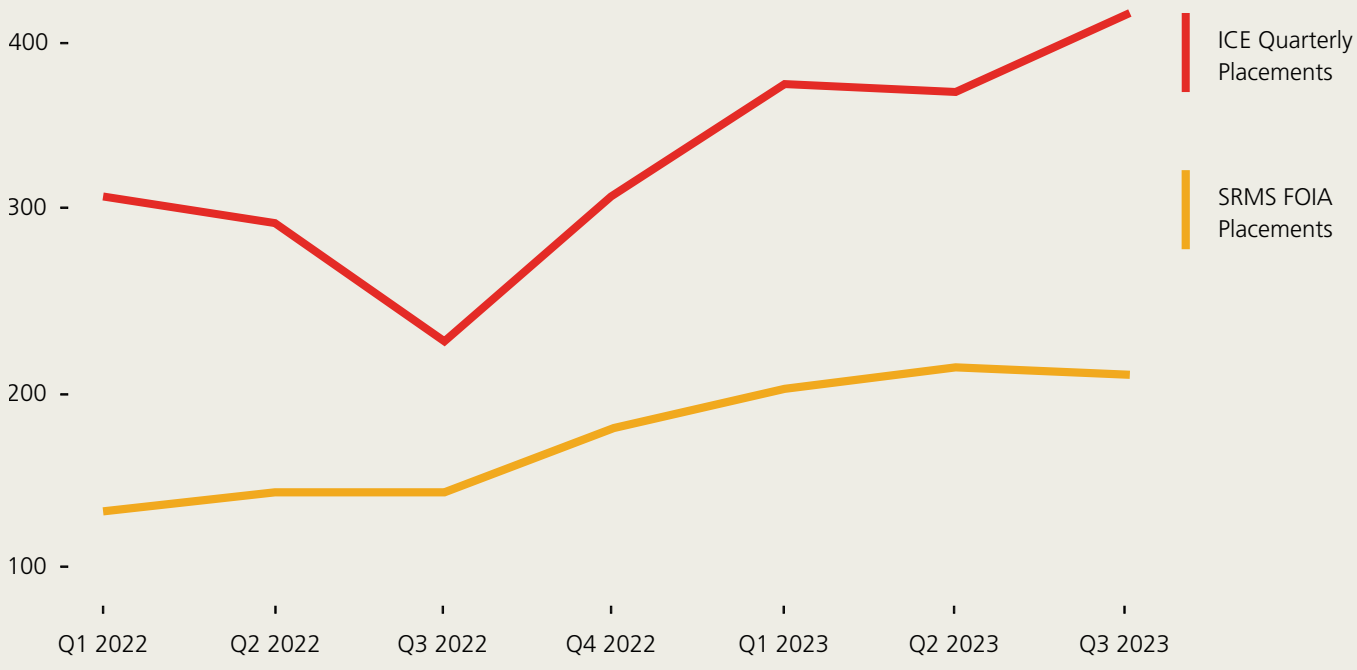
Limitations of FOIA Data Analysis

ICE has consistently provided inaccurate information about the use of solitary confinement in immigration detention facilities via its SRMS. Firstly, the SRMS data documented far fewer placements of people in solitary confinement than calculated by the OIG in its 2021 report, in which OIG obtained records directly from detention facilities for a sample of 474 individual "segregation" placements from fiscal years 2015 to 2019.[55] Specifically, the SRMS dataset for these chosen placements lacked about 16 percent of the solitary confinement placement records that the detention centers reported for the same time period.[56]

Second, comparing ICE's SRMS data with vulnerable population data trackers, a 2022 report from the GAO revealed underreporting.[57] To reach this conclusion, GAO compared data produced by ICE to available vulnerable population data trackers and found serious discrepancies with the SRMS data.[58] For instance, it found that only about 76 percent of people with a mental health condition and only about 12 percent of the people with a serious mental health condition were actually reported by SRMS.[59]

Inconsistencies with SRMS data continue, as data that ICE has only made publicly available for 2022 and 2023 reflects. Comparisons between publicly published quarterly ICE aggregate statistics from 2022 and 2023[60] and data HLS obtained through FOIA litigation[61] revealed a substantial underreporting in the number of placements and length of solitary confinement of vulnerable populations reflected in the FOIA SRMS data.[62] According to the publicly available ICE data, there are up to twice as many placements of vulnerable immigrants in solitary confinement during 2022 and 2023 than reflected in the FOIA SRMS data.[63] In addition, the publicly available ICE data for 2022 and 2023 show that the number of placements of vulnerable immigrants in solitary confinement is increasing at a faster rate than the number reflected in the FOIA-obtained SRMS data.[64]

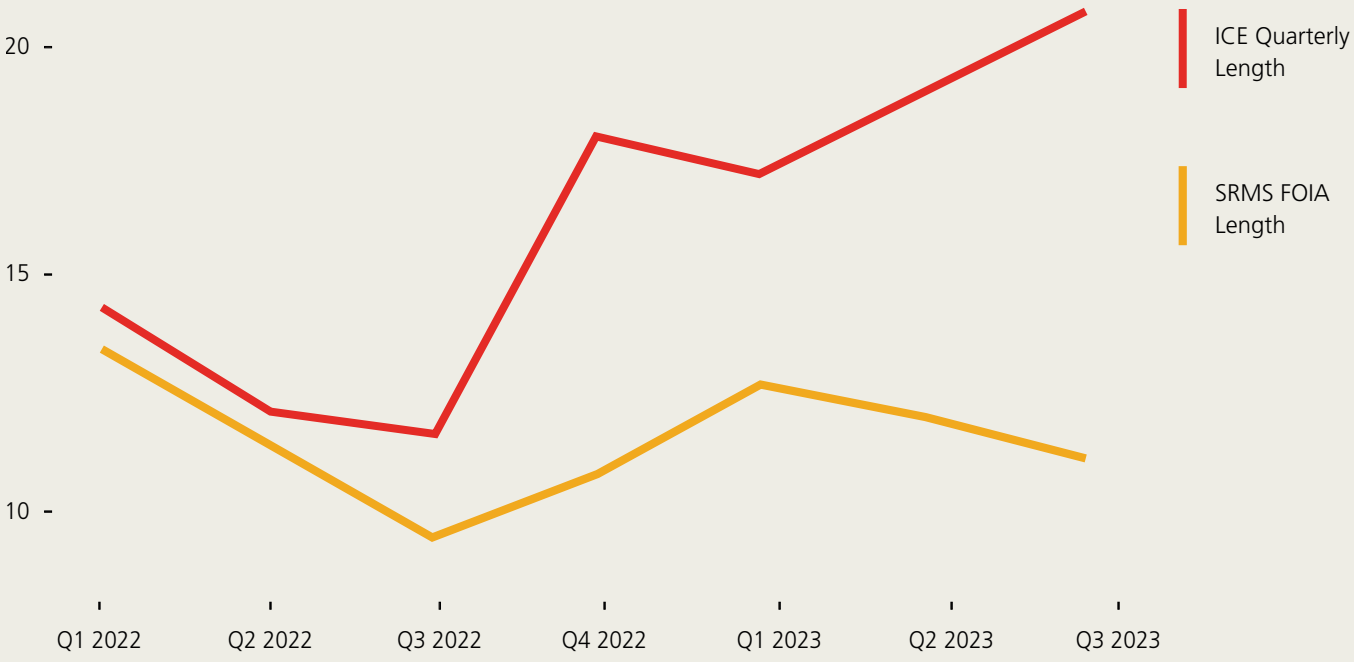
Graphic 2: Number of Solitary Confinement Placements for Immigrants With Vulnerabilities



Similarly, the average length of time in solitary confinement of vulnerable immigrants was much longer in ICE's publicly available quarterly statistics than reflected in the FOIA SRMS data. With an increasing trend, the duration of solitary confinement ranged from one to 10 days longer in the ICE publicly available reports than the FOIA-obtained estimates.[65] These publicly available quarterly aggregates of vulnerable populations suggest a strong possibility of longer solitary confinement durations for people with mental illnesses than this report shows.

Lastly, CRCL evaluations also revealed that immigration facilities misrepresented their use of solitary confinement.[66] One CRCL evaluator encountered an "especially disturbing" incidence of misreporting at the Houston Contract Detention Facility in 2014.[67] Though ICE policy requires staff to offer programs in a comparable fashion to detained persons in administrative "segregation" and those in the general population – and the staff at the Houston facility actively assured the evaluator that they had complied with this – the evaluator reported that "none of this turned out to be true."[68]The evaluator found that immigrants in administrative "segregation" were denied access to programs, shackled, and locked in their cells for approximately 22 hours a day.[69] The staff's offering of misinformation "compromised the integrity of [the] facility review."[70] Without accurate ICE reporting, other immigrants may similarly suffer in silence. Due to a combination of these issues, this report may in fact underrepresent the total number of immigrants placed in solitary confinement, their mental statuses, and their durations in confinement.

Graphic 3: Length of Solitary Confinement for Immigrants With Vulnerabilities



Methodology and Limitations

continued

Structured Interviews with Formerly Detained People

From March 6 to August 17, 2023, the HMS research team conducted 26 interviews with people formerly detained in immigration detention using a standardized questionnaire developed by the research team. All study participants were 18 years of age or older, had been released from immigration detention, and had experienced at least one period of solitary confinement during detention in the United States after September 4, 2013. This date corresponds to the day in which the ICE "Segregation Directive" was published that ordered limits on the usage of solitary confinement in detention centers and contained a pledge to "ensure the health, safety, and welfare of detainees in segregated housing."[71] All interviews were conducted by WhatsApp or standard telephone call, in languages in which participants were fluent (English or Spanish). While the study was open to speakers of any language, all participants spoke either fluent English or Spanish, so no outside interpreters were necessary. Interviews lasted approximately one hour. Participation was voluntary, and all participants provided verbal informed consent to participate in the study. A $40 electronic gift card was offered to participants as reimbursement of a standard meal and phone minutes. This study was reviewed by the HMS Institutional Review Board and determined to be exempt from further review. The study was also reviewed and approved by PHR's Ethical Review Board.

Structured interviews were based on a questionnaire (see Appendix A) that was designed to assess the implementation of ICE's National Detention Standards (NDS) (Version 2.0, 2019).[72,73] The questionnaire included three sections: 1) Demographics; 2) Solitary Confinement Conditions; and 3) Solitary Confinement Experiences. The data collected during the interviews were both quantitative and qualitative in nature. All quantitative data were statistically analyzed in Excel (Version 16.40).

Participant Recruitment

Participants were recruited through outreach to immigration attorneys. Attorneys were asked to present information about the study to clients released from immigration detention who met inclusion criteria using a standardized script and flyer. Additionally, participants were able to refer other potential study participants.

Attorneys and participants were notified that this study did not include a language restriction. All referral information was placed into an anonymous, secure REDCap referral form. Referral information included the participant's phone number, time availability, preferred language, and preferred mode of contact (WhatsApp or telephone). Names of participants were not requested or collected via the referral form to ensure anonymity and protect participants. Thirty-two potential participants were referred to the study and contacted by research staff. Six referred persons either decided not to participate or were unable to be reached to schedule the interview. Twenty-six people participated in the study and completed the entire questionnaire verbally. All participants accepted the electronic gift card.

Human Subjects Protections

Most participants were contacted through WhatsApp, which provides end-to-end encryption. For participants who did not have or prefer WhatsApp, a regular telephone line was used to conduct the interview. Prior to initiating the interview, the consent form was verbally reviewed with participants in its entirety, and verbal consent was obtained. Written consent forms in participants' preferred language were also sent prior to the interview or offered. Participants were assured that their interview was confidential, that no identifying information would be collected, and that none of their responses would be communicated to their attorney or affect their pending immigration case (if they had one – many had already been deported). During the interview, quantitative and qualitative data was collected in real time in a secure REDCap database. No identifying information was collected or stored. Participant information (including the participant's phone number) was collected in a separate REDCap database that could not be linked to participants' survey responses. Finally, participants who accepted the electronic gift card for participation were sent the electronic gift card through WhatsApp, short message services, or, if preferred, e-mail. Any e-mail communication with lawyers and participants was conducted through a Harvard Medical School delegated-access e-mail account used exclusively by study staff, and all correspondence was deleted 30 days after completion of the study. The study staff's WhatsApp accounts used to contact participants and conduct the interviews were also cleared of correspondence data after completion of all interviews.

Limitations of the Interview Study

The data presented in the report represent the reported experiences of 26 people held in immigration detention in a limited number of facilities across the United States. Given the study's modest sample size, we do not capture the full range of experiences of ICE-detained people experiencing solitary confinement in the United States. Additionally, some facilities were only known to the participants by their state location rather than the city, so it was not possible to know how many distinct facilities were represented. The interview portion of this study may also suffer from sampling bias in that attorneys may have only referred specific participants whom they felt would be comfortable participating. Participants sometimes referred friends they had made while in detention together, representing additional sampling bias. Although this study did not include a language restriction, lawyers may have been more likely to refer clients with whom they could communicate more easily without the use of an interpreter. This data was also subject to potential recall bias, as responses were based on participant memory of detention conditions. There was potential for variation in interview style among interviewers, but care was taken to minimize this variability through extensive interviewer training before and during the study period and by including at least two staff members per interview (one interviewer, one recorder) for each interviewer's first interview. The use of a structured questionnaire with consistent wording was designed to reduce interviewer bias. Prior to publication, the authors of this report had the opportunity to present the findings to key personnel in DHS and ICE.

Key Findings

View from Government Records

Immigration Detention Facilities Used Solitary Confinement Extensively

One of ICE's directives recognizes that the use of solitary confinement "is a serious step that requires careful consideration of alternatives" and calls on facilities to limit their use of solitary confinement only to situations where it is "necessary."[74] Despite this standard, ICE documented well over 14,000 solitary confinement placements in the past five years alone.[75] These placements lasted 27 days on average, well in excess of the 15-day period that constitutes torture, as defined by the Special Rapporteur on Torture. Indeed, with a median length of confinement of 15 days, nearly half of the recorded placements exceeded 15 days and many placements lasted far longer: 682 solitary confinement placements lasted at least 90 days, while 42 lasted over a year.[76] In almost 30 percent of solitary confinement placements lasting over 90 days and 25 percent of placements lasting over 365 days, the people placed in solitary confinement suffered from a mental health condition.[77]

Additionally, the FOIA data reveal numerous egregious examples of facilities holding people in solitary confinement for years at time:[78]

- Just under two years (727 days) (Denver Contract Detention Facility, CO)
- Over a year and a half (759 and 567 days) (Otay Mesa Detention Center, CA)
- Over a year and a half (652 days) (Buffalo Service Processing Center, NY)
- Over a year and a half (637, 559, and 550 days) (Northwest ICE Processing Center, WA)
- Just under a year and a half (526 days) (Eloy Federal Contract Facility, AZ)

Strikingly, for-profit corporations operate all five of the facilities with the longest periods of detention.[79]

The Northwest ICE Processing Center also had one of the highest (ninth out of 125) average lengths of solitary confinement stays on record (average length at this location was 55 days).[80] Conditions at the Denver Contract Detention Facility were also poor overall: the average length of stay at this facility between 2018 and 2023 was 52 days.[81] The American Immigration Council and other groups have documented the repeated misuse of solitary confinement at the Denver facility and in July 2023 filed an administrative complaint with DHS's Office of Inspector General, CRCL, Office of the Immigration Detention Ombudsman, and ICE's Office of Professional Responsibility.[82]

Data Spanning Several Years Shows No Improvement

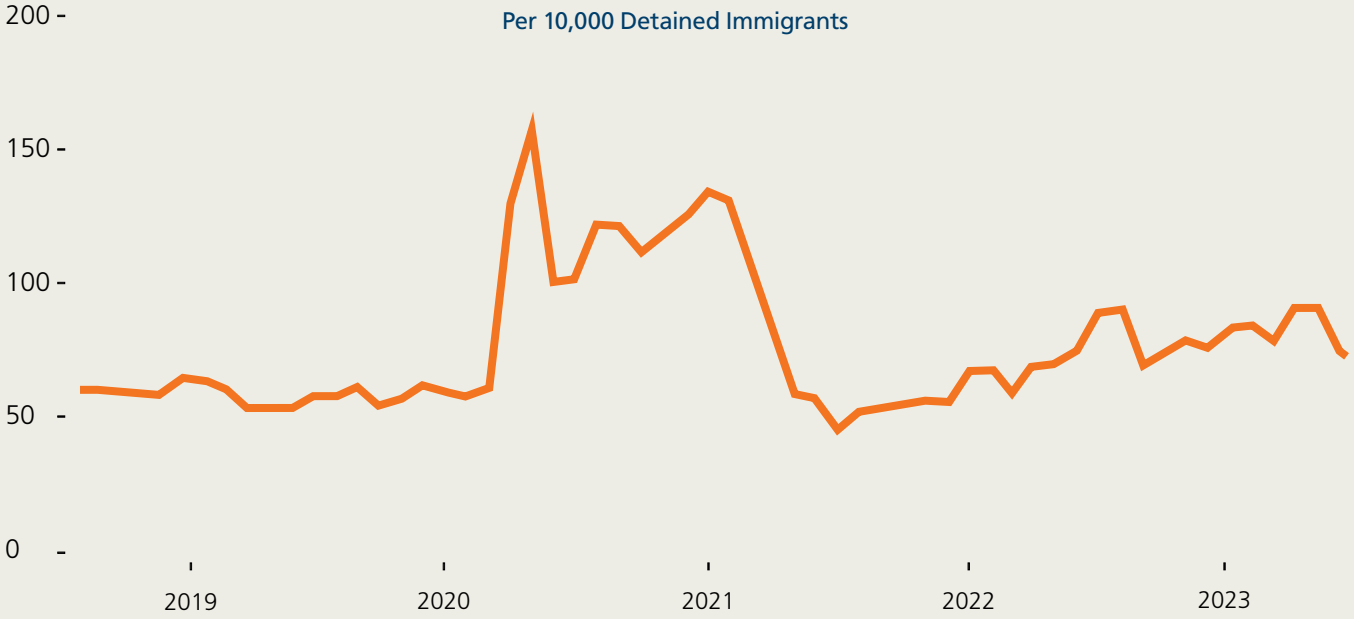
In every year between 2019 and 2022, there were several thousand new solitary confinement placements (between 2,000 and 3,300), reported in immigration detention.[83] As of September 2023, there were already 2,301 reported placements.[84] In light of the recent uptick in immigration enforcement,[85] and assuming a similar number of new solitary confinement placements in each of the remaining four months of 2023, the total number of placements in solitary confinement for 2023 likely surpassed 3,000 people.

The proportion of people in solitary confinement in ICE, out of the total number of those in ICE detention overall, has varied over time.[86] This number spiked in 2020 in conjunction with COVID-19 because immigration detention facilities used "solitary confinement under the guise of medical isolation."[87] While the number of people held in solitary confinement has declined from its peak in 2020, there has generally been an upward trend in the percent of people detained who are held in solitary confinement since its lowest point in mid-2021.[88]

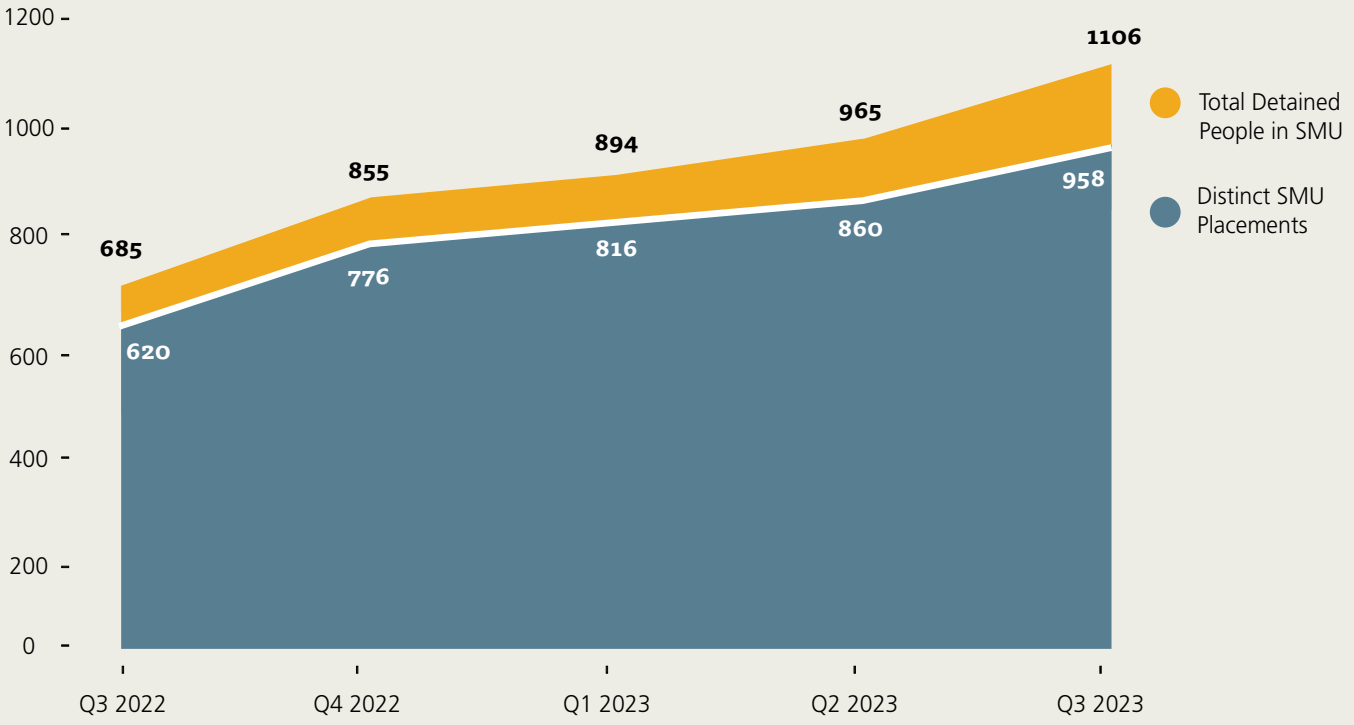
According to ICE's own quarterly reports, there were 1,106 solitary confinement placements in the third quarter of 2023.[89] This represents a 14.6 percent increase from the previous quarter, and a 61 percent increase from a year ago, based on the most recent data that ICE had released at the time this report was written.[90]

Also, the average length of solitary confinement placements remained well above 15 days in each of the past five years.[91] For 2023, this average was already at 23 days by September.[92] The average length of placements was 65 days for people who were placed in solitary confinement but were not released by the date ICE produced the SRMS data. As it is unknown when and if they were released, this is an underestimate.

Graphic 4: Number of Immigrants Held in Solitary Confinement out of Total Population in Detention



Graphic 5: Detained People in "Special Management Unit" by Fiscal Year

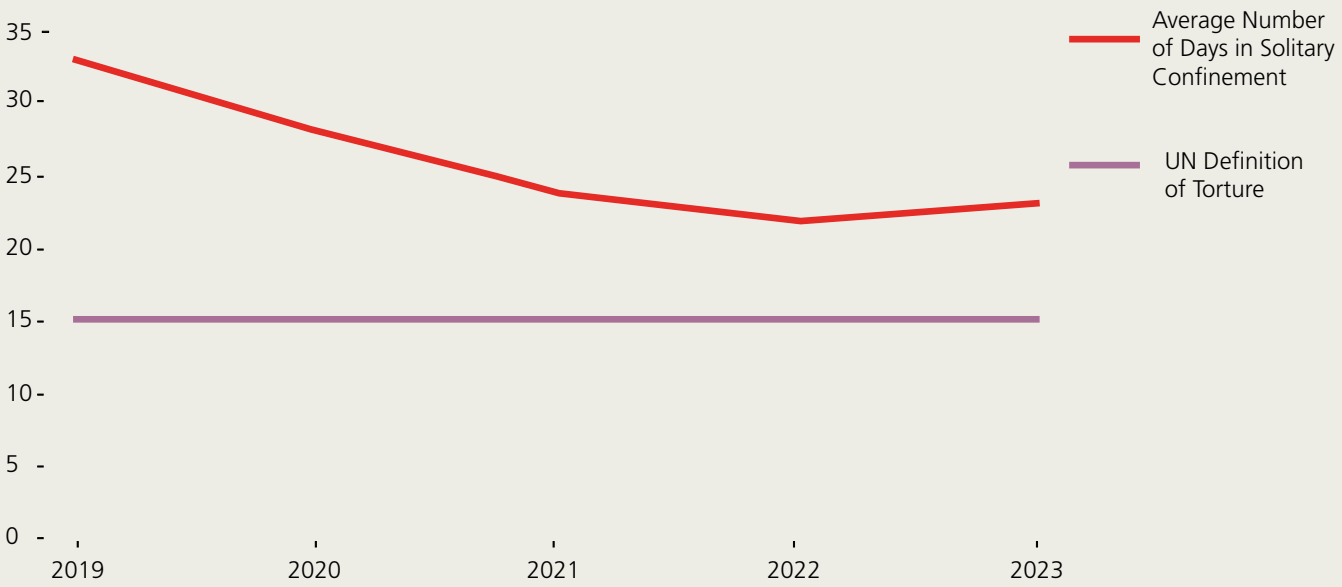


Note: ICE released this graph of 2023's third quarter solitary confinement statistics on October 16, 2023.

Key Findings

continued

Graphic 6: Average Number of Days in Solitary Confinement



Solitary Confinement Used Arbitrarily and as Punishment
Immigration detention facilities are authorized to use solitary confinement only as a last resort.[93] Yet facilities often placed immigrants in solitary confinement to punish minor disciplinary infractions. For example, FOIA documents indicate that on at least one occasion an immigrant was placed in solitary confinement for 29 days for "using profanity" and two immigrants were placed in solitary confinement for 30 days because of a "consensual kiss."[94] In another record, ICE documented that an immigrant was placed in solitary confinement for 38 days because they "refused to get out of bunk during count."[95]

This pattern of arbitrary solitary confinement placement is reflected in the administrative complaint filed regarding the Denver Contract Facility, where the facility put one person in solitary confinement for "eating too slowly."[96] This same person faced solitary confinement 10 more times, for similarly groundless reasons:

> " If I climbed on top of a table to get a guard's attention, solitary [confinement]. If I had suicidal thoughts, solitary [confinement]. When the guards would tease me about being deported back to my home country and make airplane sounds at me and gesture like a plane was taking me away, I would become upset and then get solitary [confinement] for being upset."[97]

In other cases, immigration detention facilities appear to have deliberately discriminated against immigrants identifying as transgender.[98] In 2014, a CRCL evaluation of the Houston Contract Detention Facility found multiple incidents of facility discrimination against transgender immigrants.[99] The evaluator stated that transgender immigrants were disproportionately subjected to security measures typically used for immigrants placed in solitary confinement for aggressive behavior, such as "lock-down in their cells[,] use of cuffs for movement within the facility [and] inability to attend groups available to general population inmates."[100] CRCL further noted that this treatment can "cause mental trauma and distress that resulted in avoidable suffering, depression, and suicidality."[101] "The FOIA data included 62 detainees that were placed in confinement for the following reason: "Protective Custody: Lesbian, Gay, Bisexual, Transgender (LGBT)."" The average length of stay for these detainees was 57 days, with a median of 34 and maximum of 286 days. In addition, a recent ICE report with quarterly statistics on solitary confinement reveals that the number of transgender immigrants in solitary confinement more than doubled (increased by 114 percent) in the third quarter of 2023, the most recent quarter of available data shared by ICE.[102]

Unsafe Detention Facility Conditions Exacerbated the Misuse of Solitary Confinement

Immigration detention facilities often placed people in solitary confinement to purportedly address issues such as overcrowding and threats to harm staff and/or other people in detention. In 2016, a facility put one person in administrative "segregation" "due to no available [bed] space" elsewhere in the detention center.[103] The facility's staff left this person in administrative solitary confinement for 372 consecutive days because she requested to remain there "due to being afraid of being around other detainees." Yet she was diagnosed by the facility psychologist as having multiple severe mental health conditions: PTSD and Major Depressive Disorder (MDD).[104] Though this person was not the only person to request solitary confinement in detention, solitary confinement is not an appropriate solution to a lack of safety among the general detention center population.

When people requested solitary confinement or facilities put them in it for other non-disciplinary reasons, they have been unable to "make any legal calls, have legal visits, [and] have access to [their] legal documents."[105] Solitary confinement under the guise of protection can also be life-threatening. In one person's words,

> " [the staff] told me solitary kept me safe and helped me, but it was only ever a punishment . . . I have tried to kill myself three times already because of this endless nightmare and the consistent torture of solitary confinement."[106]

Another person felt that the stress of returning to solitary confinement was "too much for him to bear," and he also attempted suicide.[107]

People with Mental Health Conditions Unfairly Discriminated Against

According to the UN Special Rapporteur on Torture, people with mental health conditions should not be held in solitary confinement.[108] ICE's 2013 "Segregation Directive" mandates that its facilities must not place vulnerable populations in solitary confinement unless as a "last resort."[109] Yet many of the people placed in solitary confinement in immigration detention between 2018 and 2023 had documented mental health conditions and it was unclear what alternatives, if any, to solitary confinement were considered.[110] Among the 8,788 records for this period where ICE's SRMS reported the mental health status of immigrants in solitary confinement, over 40 percent had documented mental health conditions.[111] In the redacted SRMS spreadsheet produced in the FOIA production,[112] ICE reported immigrants' mental health status in only 62 percent of its total solitary confinement records. Based on multiple findings of discrepancies with SRMS data,[113] the actual number of immigrants with mental health conditions who were placed in solitary confinement between 2018 and 2023 could be much higher.

The percentage of immigrants with mental health conditions placed in solitary confinement jumped from 35 percent in 2019 to 56 percent in 2023.[114] Additionally, while SRMS reported that 20 percent of the solitary confinement placement records for immigrants with mental illnesses in 2019 involved an immigrant with a serious mental health condition, close to 27 percent of immigrants with mental health conditions in solitary confinement in 2023 were classified as suffering from a serious mental health condition.[115] Among people whom SRMS labeled as suffering from a mental health condition, the average length of stay in solitary confinement was approximately 23 days; however, the average length in solitary for detained persons suffering from a serious mental health condition was 33 days.[116]

Some of the facilities with highest average confinement lengths for immigrants with mental health conditions included the Richwood Correctional Center (LA), Denver Contract Detention Facility (CO), Yuba County Jail (CA), Otay Mesa Detention Center (CA), and Henderson Detention Center (NV).[117] The average length of solitary confinement for immigrants with mental health conditions at these facilities ranged from three to six months.[118]

Immigration detention facilities also likely violated the 2022 ICE directive related to the treatment of immigrants with serious mental health conditions by denying immigrants with mental health conditions the "necessary and appropriate treatment and monitoring" that the directive requires.[119] For example, the 2023 CRCL memorandum reported how one immigrant was placed in solitary confinement even though they suffered from MDD, bipolar disorder, PTSD, and schizoaffective disorder or psychosis; their placement in solitary confinement caused "the delay or discontinuation of important mental health medications."[120]

Immigration detention facilities also used mental health conditions as a justification for placing immigrants in solitary confinement despite the well-known negative effects of solitary confinement.[121] In one record, ICE reported that a "[s]ubject was placed in protective custody after he was not able to properly care for himself in general population. Subject has been diagnosed with schizophrenia."[122] This person was held in solitary confinement for 56 days.[123] In another instance, an individual with a mental health condition was held in solitary confinement for 28 days because they reportedly responded to officers with "irrational answers" and were observed making "unusual body movements."[124]

Key Findings

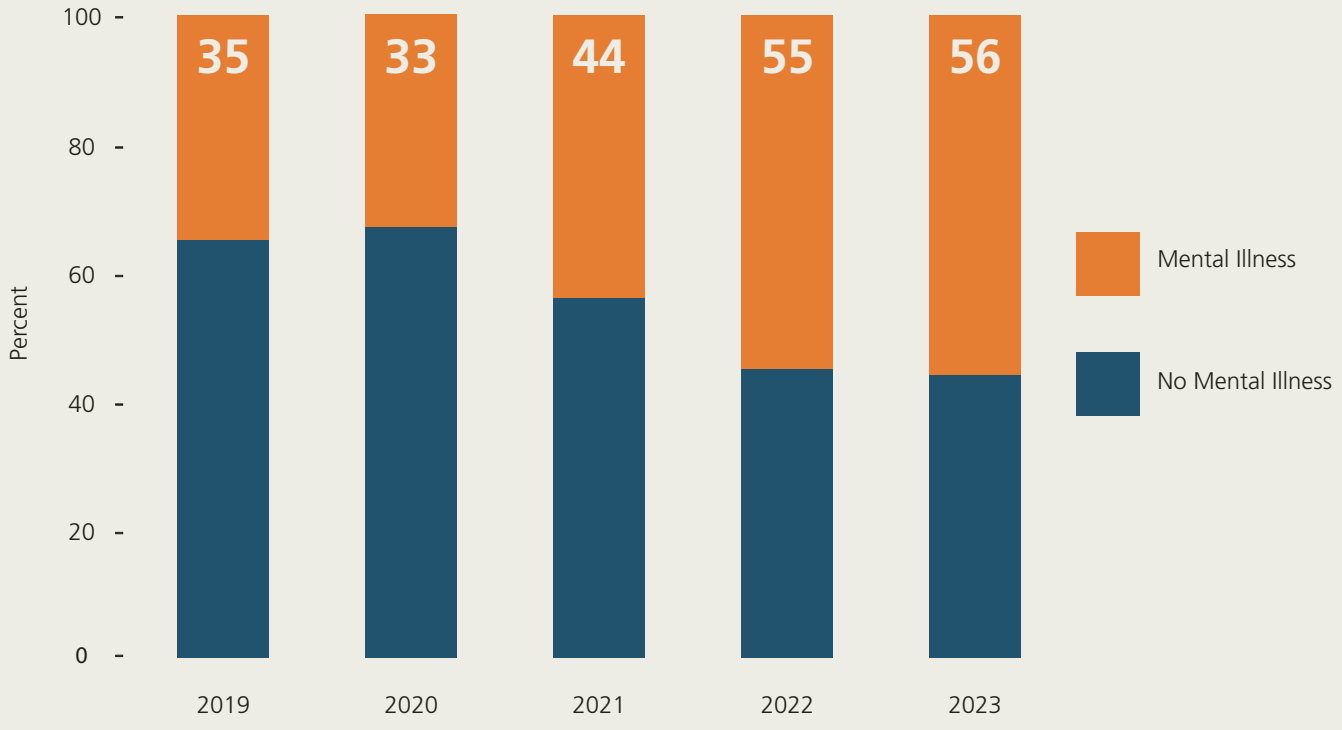
continued

Substandard Medical Care in ICE Custody Caused Severe Health Consequences

ICE's failure to ensure adequate medical resources in detention centers created life-threatening conditions for immigrants in solitary confinement. CRCL reported that between 2012 and 2014, some facilities left immigrants without any meaningful access to a mental health professional.[125] In at least one facility, mental health professionals stopped working altogether.[126] Another facility had nursing staff without psychiatric training performing suicide risk assessments, staff giving medications to immigrants without their consent, and medical forms lacking immigrants' past medical histories.[127] These conditions can acutely impact immigrants in solitary confinement.[128] For instance, one of CRCL's evaluations reported that an immigrant was "[u]nable to sleep" and "starting to have hallucinations due to being locked in cell all the time."[129] This immigrant stated that his depression was "getting worse day-by-day."[130]

Immigration facilities also punished suicidal immigrants with solitary confinement.[131] At one facility evaluated by CRCL in 2012, facility staff "actively discourage[d] [suicidal] detainees from seeking help."[132] This hostile environment was created by staff that forced suicidal immigrants to undress except for a safety smock and remain in solitary confinement without access to counseling until they denied their "current suicidal thought[s]."[133] These procedures humiliated and punished immigrants in critical need of medical care.[134]

Graphic 7: Percent in Solitary Confinement With Mental Illness



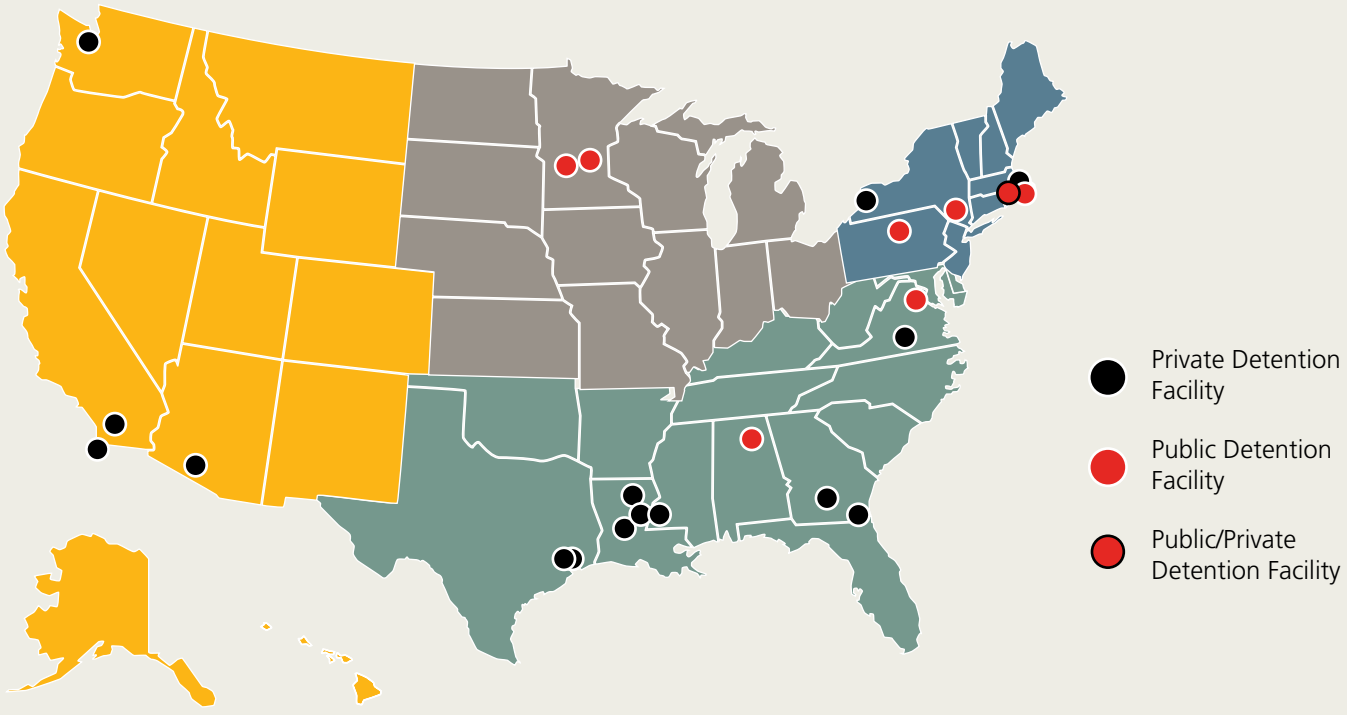
In Their Own Words: Interview Findings of Experiences in ICE Solitary Confinement

Participant Demographics

Twenty-six participants were interviewed (questionnaire provided in Appendix A) in total; 23 identified as male (88 percent), and one each identified as female, agender, and transgender man (4 percent each). Interviewee ages ranged from 29 to 56 years old (average 36.2 years). Participants were originally from 19 different countries, including 31 percent who were from Mexico, 23 percent from Colombia, and 12 percent from Honduras. Eight percent of the people were multilingual, comfortably speaking more than one language. Thirty-one percent of the participants felt "uncomfortable" or "very uncomfortable" speaking English and would have very likely required translation services while in detention to easily communicate with non-bilingual staff members. A comprehensive list of countries of origin and languages spoken by participants is included in Appendix B.

These 26 participants were detained in at least 34 unique detention facilities in the United States – representing 11 county/public facilities, 22 private facilities, and one mixed-status facility – across 17 different states. Some participants could not recall the exact name or city of the facility in which they were held, so this list is not exhaustive of the locations where interviewees were detained and/or experienced solitary confinement. Of the private facilities, 12 were run by GEO Group, five by CoreCivic, and one facility each by Ahtna Support and Training Services, Immigration Centers of America, LaSalle Corrections, and Valley Metro Barbosa Group. One location, the Donald W. Wyatt Detention Facility, is publicly owned but privately operated. Of the 34 identified facilities, people experienced solitary confinement in 23 of them (68 percent).

Graphic 8: ICE Detention Facilities Where Study Respondents Reported Experiencing Solitary Confinement



Key Findings

continued

Misuse of Solitary Confinement

Spending up to a Year in Solitary Confinement

Interviewees experienced an average of 3.6 separate stays in solitary confinement (range 1–30 stays). Each stay lasted an average of 32.2 days, with a median of 14 days. This is nearly six days longer than the average confinement in "segregation," as seen in the FOIA data between 2018 and 2023. There was substantial variation in how long detained persons stayed in solitary confinement, as seen in Graphic 9.

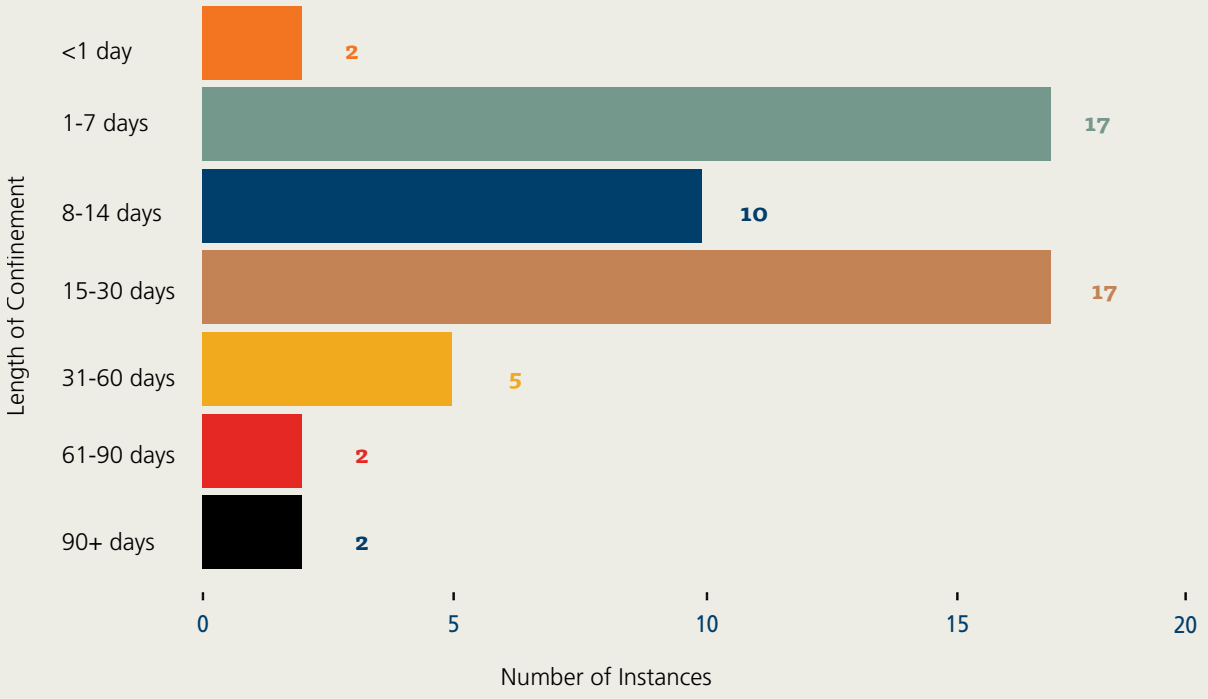
Out of 55 described distinct placements in solitary confinement, a majority (61 percent) lasted longer than 14 days (what ICE defines as "extended segregation"), and 37 percent were greater than a month. One person stated that they were in solitary confinement for more than a year (32-year-old agender person, Etowah County Jail).

Solitary Confinement Was Often Misused as Punishment

The most commonly reported reason for solitary confinement placement was disciplinary "segregation" (n=16, 62 percent) (Graphic 10). ICE's standards explicitly state that disciplinary "segregation" can only be used after receiving "a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions would inadequately regulate the detainee's behavior."[135] However, only seven (44 percent) of those placed for disciplinary reasons received an official hearing for disciplinary "segregation." The majority did not receive this due process. One person reported that intimidation was used to dissuade him from having hearings. Instead, he was encouraged to plead guilty to the charges, because, contrary to guidance and directives, he was told that if he went to a hearing, "they would often double the punishment or the time. So instead of 10 days, suddenly you would get 20–30 days" (30-year-old man, Kandiyohi County Jail).

Accounts from study participants conflicted frequently with the regulations as outlined in the aforementioned ICE "Segregation Directives." Solitary confinement was commonly used to punish people who submitted complaints, organized protests, or required medical isolation. For instance, eight people (31 percent) reported being put in solitary confinement after participating in a hunger strike.

Graphic 9: Length of Stay in Solitary Confinement in Days, Per Instance of Solitary Confinement Among Interviewees



"If you don't listen to their rules, that's a reason to go to the hole. If you don't do anything they ask you, that's a reason to go to the hole."

35-year-old man, Caroline Detention Facility

The decision to place someone in solitary confinement often relied on the discretion of correctional officers, leading to instances where detained persons were placed in solitary confinement as a punitive measure despite not having done something that would warrant disciplinary "segregation." One participant shared that he was assaulted by one of the officers in the facility, which led to chest pain. He then tried to relay his medical concern:

> " I had chest pain [from the assault] but the correctional officer said I was lying so they put me in solitary confinement."
> *34-year-old man, Bristol County Correctional Facility*

Solitary confinement was also abused for minor offenses, such as taking food from the cafeteria to their rooms. One respondent who spent nearly his entire time in detention inside of solitary confinement stated,

> " I would go on a walk without a uniform and that was enough to be put in solitary. For any minimal thing, they would find an excuse to put me in solitary. Even to use the stove to heat up coffee, they gave me 7 days of solitary [confinement]."
> *37-year-old man, Orange County Jail*

One interviewee reported a common understanding that people exhibiting symptoms of serious mental health conditions would be placed in solitary confinement instead of being connected to care. One participant said he saw people placed in straitjackets and thought of solitary confinement as where "mentally and psychologically unstable" people were placed (32-year-old man, Richwood Correctional Center).

Graphic 10: Reported Reasons for Placement into Solitary Confinement

Reason	Number of Individuals	Additional Information
Disciplinary "Segregation"	16	
Participation in Hunger Strike	8	
Medical Isolation	7	In some cases, for positive COVID-19 infection
Victim of Sexual Assault	1	
Protective Custody	2	
Suicide Risk	1	
Other	11	For retaliation (for organizing protests, participating in a riot, filing complaints), racism (for not speaking English), sexual assault allegation

Key Findings

continued

"They give you a paper saying what they say happened. If you don't agree, they put you in longer."

31-year-old man, Bristol County Correctional Facility

A Lack of Transparency

When people were put into solitary confinement, there was often uncertainty regarding how long their stay would last. Thirteen people (50 percent of interviewees) were never given an estimate of how long they were going to stay in solitary confinement, and if they were, this estimate would often change. One participant stated,

> " when you go to 'the hole' [solitary confinement] you don't know how long you are going to be there."
> *39-year-old man, Eloy Detention Center*

Study participants noted that officials exploited loopholes to keep detained persons in solitary confinement longer, through either enforcing multiple separate solitary confinement stays or transferring persons in solitary confinement between facilities.

> " They just kept me there until they transferred me, because by the policy you can't keep people for more than 2 weeks in solitary [confinement]," said one participant, "So when I complained about it, they just transferred me."
> *33-year-old man, Caroline Detention Facility*

According to various directives, those in disciplinary "segregation" should have received reviews every seven days. However, only nine people (35 percent) remember being interviewed by a supervisor and only 14 people (54 percent) received a written review of why they were placed in solitary confinement. This suggests that there was a lack of transparency with people in solitary confinement, who may have had only brief interactions with supervisors overseeing their solitary confinement stay and did not have clear communication regarding this process.

Concrete Beds and 24/7 Lights Were Commonplace

Being placed in solitary confinement meant experiencing substantially worse living conditions than those in the general population at those same facilities. While specific descriptions of each cell differed, almost every participant described minimal furniture, uncomfortable bedding, small room sizes, and small windows. Eleven people (42 percent) reported having worse mattresses and bedding in solitary confinement compared to those issued in the rest of the detention facility. Specifically, seven people reported bedding was of poorer quality or described having no mattress at all, noting that the "bed was made out of cement with no cushion, only a blanket" (29-year-old man, unknown center in Louisiana) or just steel surfaces.

Interviewees described a lack of autonomy over basic control of their living conditions. One participant described how

> " the correctional officer (CO) had control of the light and flushing of the toilet; [I] had to bang the door and say 'CO, bathroom! or CO, light!'"
> *34-year-old man, Bristol County Correctional Facility*

ICE standards require that all "cells and rooms used for purposes of "segregation" must be well-ventilated, adequately lit, appropriately heated/cooled, and maintained in a sanitary condition at all times, consistent with safety and security."[136] Despite these specifications, the lighting and temperatures of the rooms were controlled by the facility staff to create uncomfortable living conditions, leading to sleep deprivation and disorientation as to the time of day. For example, several people described the temperature in the rooms as being unbearably cold, with the air conditioner on at all times and not being provided blankets or jackets if they asked.

One person stated,

> " I lost all sense of time – lights were on all the time and there were no clocks on the walls or windows"
> *32-year-old man, Richwood Correctional Center*

"The light is on 24 hours a day … the guards wouldn't dim or turn them off at times … we went crazy, we tried to cover those lights with paper."

30-year-old woman, Irwin County Detention Center

Twenty people (77 percent of interviewees) described having fluorescent lights in their room that were turned on either 24 hours per day or for prolonged periods, such as from five in the morning until midnight.

Keeping lights on for prolonged periods of time is known to cause sleep deprivation through dysregulation of the body's natural sleep–wake cycles, or circadian rhythm, and may lead to cognitive disorganization, paranoia, and hallucinations.[137] These conditions included social isolation, constant bright lighting, and cold exposure are well-documented strategies for torture and interrogation designed to inflict psychological distress and have been described in immigration detention settings in the United States.[138]

Smaller and Worse Meals in Solitary Confinement

ICE's own standards state that while in detention, people should be given "nutritious, attractively presented meals" and that "food rations shall not be reduced or changed or used as a disciplinary tool."[139]

However, eight people (31 percent) reported that their meals in solitary confinement were worse than those served to the general population. Three people said that the portions were smaller than usual – even half the size of normal. Although most participants reported being served three meals a day, three people reported that the facility sometimes only provided two meals (breakfast and dinner) a day to them while in solitary confinement. When one participant asked for water, he was told

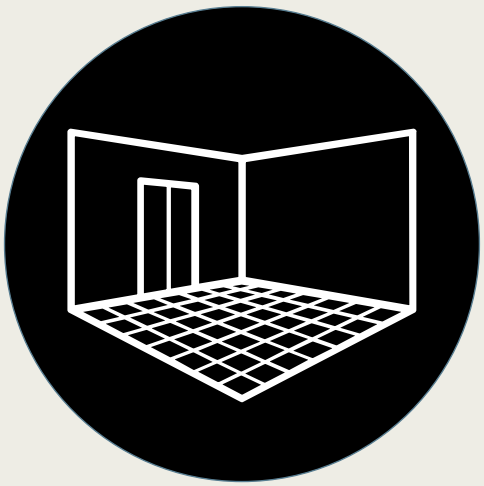
> "to drink water from the toilet"
> *37-year-old man, Orange County Jail*

When one participant asked for water, he was told "to drink water from the toilet"

37-year-old man, Orange County Jail

Graphic 11: One Interviewee's Description of the Solitary Confinement Cell

Individual
56-year-old man originally from Italy



Room

"7 feet by 12 feet in length."

"All concrete: floor, ceiling; bricks on the walls all painted in white. A concrete desk and a concrete stool attached to the floor."

"The toilet and sink were stainless steel and placed in the corner. Issues related to flushing over flushing and overflow from the adjacent cell."

Bed

"The bed was something called 'the boat,' which is a steel platform with pipe around which allows the guards to handcuff you in both your wrists and your ankles and render you completely immobilized."

"On top of that was a padded sheet that they call a mattress, but it's not a mattress. No pillows, two sheets."

Lighting

"The windows to the outside was (sic) scratched to the point that you couldn't see anything to (sic) the outside, you could only see if it was day or night. The windows to the outside was (sic) maybe 3 feet in height and 3 inches in width."

"The lighting was probably 12x36 inches, was on the ceiling, was fluorescent, was flickering sometimes, and had a buzzing sound that makes people crazy. Guards controlled the "lights from the outside."

Meals could also be of such poor quality that the food was inedible, because it was either expired or unappetizing, such as resembling "vomit" (32-year-old agender person, Etowah County Jail) or "soggy tuna on bread" that looked like "cat food" (29-year-old man, unknown center in Louisiana).

Dietary restrictions for various medical conditions or religious exemptions were not always accommodated. One interviewee with food allergies said that he "told the kitchen [about the allergy], they told me to talk to the doctor. Then the doctor told me to talk to the kitchen. I couldn't eat anything for months. I'm allergic to the turkey, I'm allergic to basically everything. So, I didn't eat most of the time in there." (41-year-old man, Golden State Annex). Another participant shared that, "I asked for a halal meal and the correctional officer was like 'when you want to eat good food, go back to Africa.' He said, 'if you don't eat this, I'm not giving you no food.' But that's my right to eat halal meals." (34-year-old man, Bristol County Correctional Facility).

Access to Communication and Services

Restricted Legal and Personal Communications

While people were held in solitary confinement, all communication outside of the detention center was closely monitored and restricted. Seven people (27 percent of the participants) were never able to call anyone on the telephone while in solitary confinement, and eight people (31 percent) could not write or receive letters. The remaining interviewees often had significant limitations on who they could talk to, even facing cases where "they blocked every number on my phone. It got to the point where I was only able to talk to my attorney" (38-year-old man, Montgomery Processing Center). These constraints meant that sometimes people could not let their loved ones know that they were in solitary confinement. There were also time limitations (as brief as five minutes per call), prohibitive costs (video calls cost $3 a minute), and sparse access to phones (sharing one telephone between 20 to 40 cells). Five people also said that their calls were monitored and recorded – especially calls to their lawyers or to the press – and that they could have their connections cut if they were heard discussing the living conditions inside detention or other complaints. The majority (65 percent) of participants also experienced staff violating their privacy by not keeping mail private, One in particular cited that facility staff would "open and read your letters and decide whether or not to send them; or keep them there" (34-year-old man, Bristol County Correctional Center).

These restrictions on people's ability to communicate with the outside world also prevented interviewees from relaying information to their legal teams. Several people reported that the times they had to access the phone were at night, and they [facility staff] "only let me out after work hours so I couldn't get in contact with anybody" (33-year-old man, LaSalle Processing Center). Even though the National Detention Standards (NDS) maintain that detainees in SMU (Special Management Unit) "may not be denied legal visitation," people reported variable access to their lawyers.[140] While some people could see their legal team once a week, others could only reach them on the phone and faced significant barriers to receiving legal advice.

Limited Access to Recreation, Hygiene, and Religious Services

Interviewees described frequent limitations to recreation and hygiene instituted as punitive measures. Even when these rights to participate in recreation and religious events were explicitly protected in ICE's NDS guidelines,[141] people reported being unable to do so while in solitary confinement.

People in solitary confinement should be offered at least "one hour of recreation per day … at least five days a week."[142] While the remaining 23 hours were spent confined inside the cell, this one hour a day represented the only time people had to shower, talk on the phone, and use the recreational facilities. Seven people (27 percent) "rarely" or "never" received this much recreational time in solitary confinement. In these cases, the detained persons should have received a form of written correspondence about why and for how long their recreation was to be suspended.[143] Yet no interviewees received any such notice.

The NDS say that people in solitary confinement can "shower at least three times weekly" to maintain their personal hygiene.[144] A majority (73 percent) of participants could shower between three to seven times a week; however, seven (27 percent) could only shower twice a week or never. For some in solitary confinement, showering was only allowed during their limited designated recreation time, forcing them to make difficult decisions about if they should allocate their time to shower or talk to others on the telephone.

While in detention, people are reliant on the commissary to purchase basic necessities such as soap, shampoo, and deodorant. However, 15 people (58 percent) were not able to use the commissary while in "segregation" at all.

Finally, although the NDS state that persons in solitary confinement "shall be permitted to participate in religious practices" unless there is an explicit safety concern,[145] most people reported that they were not allowed to leave the cell to attend religious services and their requests to join were denied. A majority of participants (16 people; 62 percent) reported never being able to participate in religious practices while in solitary confinement. Two interviewed persons reported that they faced discrimination as Muslims: there were no specialized Islamic services, and the Qur'an was only available for purchase at exorbitant prices whereas the Bible was provided for free.

"If I ever told my wife about mistreatment during a phone call or showed my wife the living conditions during a video call they would end my call immediately."

50-year-old man, Northwest ICE Processing Center

Medical Health Care in Solitary

Lack of Regular Medical Assessments in Solitary

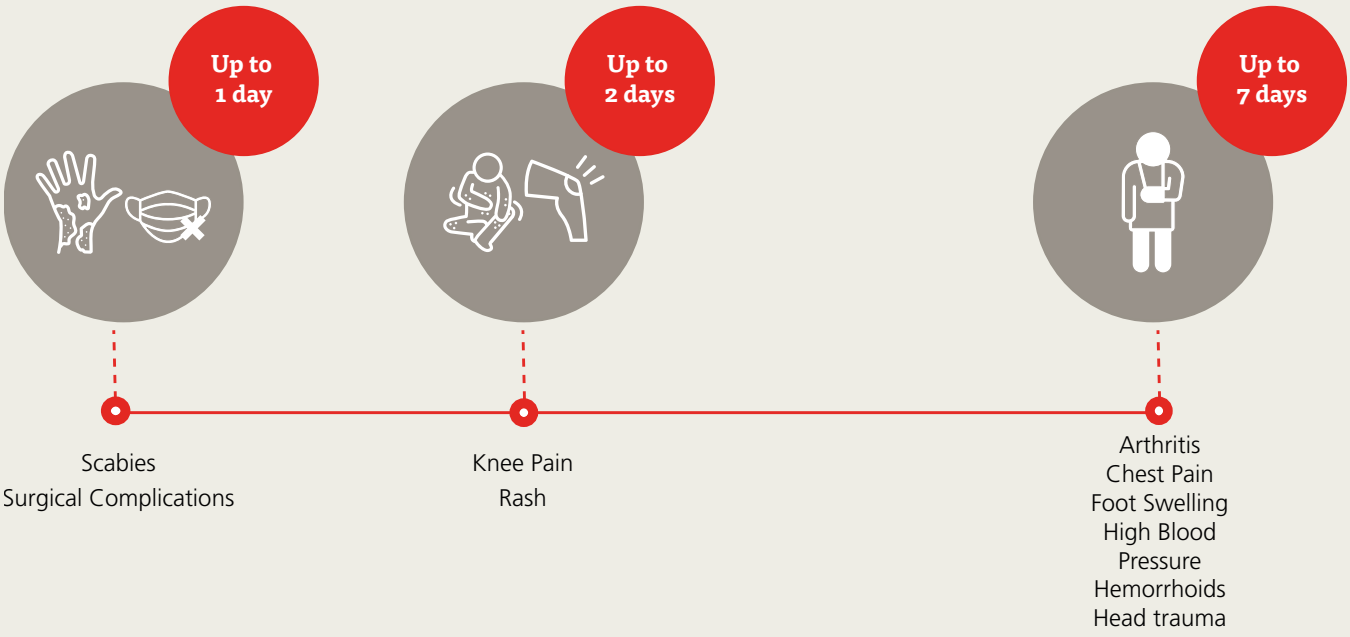
Many interviewees had significant medical needs requiring attention during solitary confinement. Fifteen people (58 percent of interviewees) had a medical condition requiring care during solitary confinement, and 12 people had new medical conditions arising while in solitary confinement. Examples of these medical conditions and the time passed before seeing a provider are listed in Graphic 12 below.

ICE regulations outline that "[d]etainees must be evaluated by a health care professional prior to placement in an SMU (or when that is infeasible, as soon as possible and no later than within 24 hours of placement)."[146] Yet, of the 26 participants included in this study, only 11 people (42 percent) reported being seen by a medical professional before being placed in solitary confinement and only nine people (35 percent) were screened for preexisting mental health conditions.

"When you're in solitary [confinement], you don't get to see any doctors, nurses, dentists, anything … There would have to be something really wrong with you … But usually you don't see any doctors, or nurses, dentists, or anything when you're in seg."

30-year-old man, Kandiyohi County Jail

Graphic 12: Days to See a Medical Provider for Each Medical Condition



In addition to the initial assessment, there should also be frequent "face-to-face medical assessments at least once daily for detainees."[147] However, only 13 people (50 percent of the study's respondents) remembered being routinely evaluated by a health care provider. Only those participating in hunger strikes or who were deemed suicide risks were consistently seen by a health care professional daily. Otherwise, the frequency with which people were seen by a health care professional varied from daily (four people) to approximately every three to four days for those in medical isolation (two people). Others, even those with chronic or acute medical conditions, were seen either intermittently or not at all over the duration of their confinement. Many recounted that it felt like staff were just going through the motions to fulfill detention center requirements and documentation.

Interviewees reported difficulty identifying the role of various health care professionals who interacted with them, suggesting that interactions were either unduly brief or that staff members failed to appropriately clarify their role during their care. As one person described,

> " [Health care professionals] come around, they make their rounds. But if you want to talk to them, you got to stop them. You got to be up at a particular time … Because they come by at 5, 6 in the morning. Otherwise you miss them."
> *38-year-old man, Montgomery Processing Center*

When participants were able to identify the types of health care professionals, the majority (56 percent) reported being seen by a nurse, with a minority being seen by physicians, physician assistants, therapists, psychologists, or medical assistants. Multiple respondents reported that nurses were the primary health care providers in these facilities; doctors were either reserved for more serious concerns or entirely unavailable. One interviewee raised concerns about the licensure of health care staff employed by the detention center, relaying reports that the doctor where he was detained had had his license suspended.

Long Waits and No Medications

Of the 14 people who submitted requests to see a medical provider, only three people (21 percent) reported being seen within 48 hours. Of the remaining cases, eight (57.1 percent) waited one week or more to be seen. Notably, these cases included potentially serious complaints such as chest pain, lower extremity swelling, and head trauma. Despite placing multiple requests for conditions including migraines, insomnia, and dental pain, three people were never medically evaluated while in solitary confinement.

There was a high bar to receive medical care while in solitary confinement, and the burden to overcome that bar rested solely with the detained person despite ICE standards requiring routine evaluations by health care providers.[148] Multiple respondents reported that their medical issues were ignored unless they were persistent with requests:

> " The thing with immigration and with the medical, they're just trying to give you the minimum. You gotta keep going and going, bugging and bugging, to get the help you need. You gotta keep bugging them, that's the only thing. So, your medical issue might be ignored in the temporary time."
> *39-year-old man, Eloy Detention Center*

Medications were also difficult to access while in solitary confinement. Six of the interviewees (33 percent) who needed medications during solitary confinement did not receive them during at least part of their solitary confinement period, with three people denied medicine the entire time. Examples of medications people were denied included naproxen (for pain relief from chronic osteoarthritis), antibiotics (for a skin/soft-tissue infection at a surgical site), and an inhaler (for wheezing and trouble breathing from asthma). Interviewees reported that they were not provided medications for a variety of reasons including participation in hunger strikes and perceived overuse by detention facility staff. One participant with a known Tylenol allergy noted that detention facility staff failed to provide appropriate alternatives, so he was denied any analgesia (56-year-old man, Buffalo (Batavia) Service Processing Center). One person even mentioned that over-the-counter medications, such as ibuprofen, were only available to purchase.

Disturbingly, two participants reported being given unknown medications without being told their purpose and against their will. They reported side effects following the administration of these unfamiliar medications, including upper extremity swelling and slurred speech, with no further evaluation or follow-up care.

In addition to poor quality of medical care, several respondents reported being denied a sense of privacy in their interactions with health care workers. Although guidelines require that "the facility shall provide out-of-cell, confidential assessments and visits for detainees whenever possible, to ensure patient privacy and to eliminate barriers to treatment,"[149] many interviewees reported that most evaluations occurred across their locked cell doors. One participant recounted, "The worst part is that they do that through the metal door, so you have to say loudly – everyone can hear your mental health conditions" (56-year-old man, Buffalo (Batavia) Service Processing Center). This treatment is in violation of the federal Health Insurance Portability and Accountability Act, which classifies peoples' health information as protected data that cannot be disclosed to others without their consent.[150]

Enough Done to be "Kept Alive," But Not Cared For

Multiple participants described substandard medical care while in solitary confinement, including denying detained persons of emergent care in life-threatening situations. One person described having to perform

> " CPR on another inmate while a guard stood there in shock .... A nurse came back later and said that there was no doctor and that they would have to wait until the next day to be seen."
> *50-year-old man, Northwest ICE Processing Center*

Another participant recounted an incident when he had chest pain with electrocardiogram findings, which could have represented a heart attack or cardiac arrhythmia, but doctors refused to transfer him to a hospital because he was getting deported that same night. These findings are consistent with the recently published finding of potential underutilization of emergency medical service systems as compared to the number of ICE-documented medical emergencies in their detention facilities.[151]

Interviewees described dehumanizing treatment while seeking medical care in solitary confinement. Three people reported being handcuffed and shackled prior to being brought to medical care, despite not being in criminal custody:

> " You could see a doctor if you put in a request ... if there was an emergency, like if there was something really wrong. I've seen guys go back there, but you would have to be handcuffed and shackled. Then you could go back to the clinic area to see the nurses and doctor."
> *41-year-old man, Joe Corley Detention Facility*

Interactions with medical providers were often cursory, with one person noting that he

> " never felt like [he] was taken care of medically and providers will do the most they can to not spend time with you."
> *50-year-old man, Tacoma Northwest Detention Center*

Another person reported that the prevailing attitude was

> " just keep him alive until they can get deported. They didn't care about how you felt."
> *35-year-old man, Caroline Detention Facility*

Lasting Negative Impacts on People's Physical Health from Solitary Confinement

Of the 15 people who required medical care during solitary confinement, 12 (71 percent) had a new medical problem while in solitary confinement. Some people attributed the development of their medical conditions to the poor sanitation in solitary confinement. As one participant described,

> " I got scabies from the solitary confinement room. All you got was a bottle of disinfectant. I sprayed and cleaned the room, but it was not good enough. It's really disgusting."
> *35-year-old man, Caroline Detention Facility.*

Other conditions were not necessarily related to their confinement, such as viral and dental infections, but still required medical assessment.

Other interviewees reported complications of existing conditions due to inadequate health care while in solitary confinement. For example, one person described an untreated leg wound that led to increased swelling and infection, which required two surgeries and put him at risk for an amputation.

The high levels of stress associated with solitary confinement could also have lasting physical impacts.

> " I would get so stressed out that there would be physical problems … lots of sweating, my blood pressure would be affected,"
> *30-year-old man, Kandiyohi County Jail;*

another had worsening migraines

> " triggered by the light [and] constant worrying about when you will get out."
> *35-year-old man, Donald W. Wyatt Detention Facility*

"There are no doctors, just nurses. When there's an emergency, they don't know how to handle it. They come, and they bring a ton of pills to the person, but they don't know what it's for or why they're using it."

32-year-old agender person, Etowah County Jail

In addition to stress and delayed medical care, others felt that the conditions within solitary confinement itself negatively impacted their health:

> " Because the room was very small, I was unable to exercise. With my eyes, I wasn't able to see very clear(ly) because of the light. The bunk hurt me. Sometimes I had to lie on the floor. My skin, rash, dry skin – it was all because I didn't have access to all the regular stuff that people in detention have access to. My back hurt, my kidneys. I was groggy all the time and tired."
> *31-year-old man, La Salle Detention Facility*

One person noted that protracted time that he spent with his hands in either handcuffs or zip-ties led to lasting sensory damage, in the form of residual numbness and tingling.

Many interviewees testified to long-lasting ramifications of solitary confinement on their physical health. Some reported continuing pain or complications from injuries that went untreated during solitary confinement, including residual back pain, chest pain, and infections. Others discussed how they were denied access to their medical information, rendering them unable to seek appropriate follow-up care after being released.

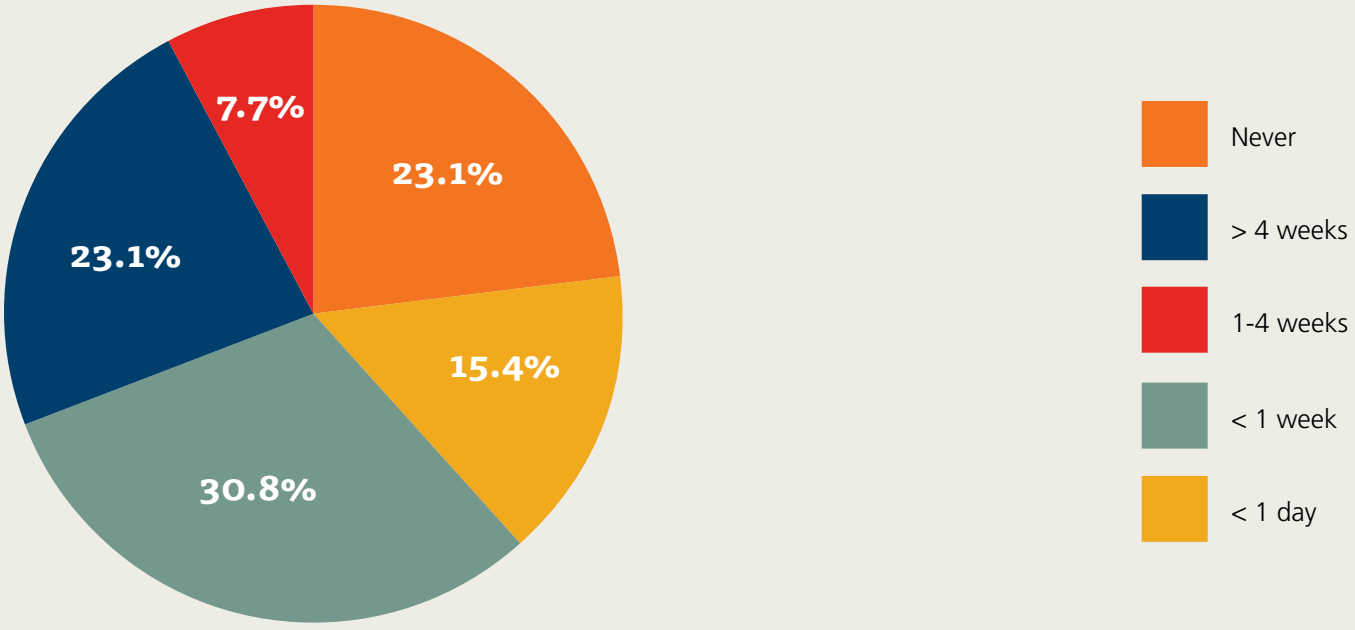
Mental Health Care in Solitary Confinement

Mental Health Care Did Not Meet Basic Standards of Care

Fifteen interviewees (57 percent) had a condition requiring mental health care while in solitary confinement, five of whom had preexisting condition(s) and the other 10 who developed symptoms in solitary confinement. These conditions and related symptoms included: anxiety, depression, PTSD, and a variety of symptoms such as paranoia and hallucinations.

While in solitary confinement, access to mental health care was limited unless officially placed on "suicide watch." Of the 15 people in solitary confinement who required mental health care assessment, 13 placed an official request to see a mental health care provider. According to ICE, people in detention are supposed to be evaluated within 24 hours after voicing a request.[152] However, only two people (15 percent) were seen within this time period. Another four people (31 percent) had their requests fulfilled in less than a week. However, three people (23 percent) were never evaluated for their mental health concerns, which included depression and PTSD, and for another three people (23 percent), it took greater than a month. Notably, someone experiencing a dissociative episode – a period often associated with amnesia and a sense of detachment from their everyday experiences or actions, commonly associated with experiencing significant trauma and PTSD – waited approximately five months before being evaluated.

Graphic 13: Reported Length of Time to See Mental Health Provider



"The numbness on [my] right hand due to prolonged handcuffs remains – it is a constant reminder. When you use a mouse, you feel the numbness."

56-year-old man, Buffalo (Batavia) Service Processing Center

Even among those who ultimately received mental health care, interactions were often brief and inconsistent. Sometimes a mental health provider might be available for "maybe 5 minutes" at a time (34-year-old man, Bristol County Correctional Facility). Study participants described that some mental health providers would come for mental health checks, but these checks mostly occurred through the doors rather than taking the person out of the cell for a private conversation. This led one participant to state that one would

> " just sign this paper outside your door that they saw you, but as far as actually engaging you? They're not engaging you."
> *38-year-old man, Montgomery Processing Center*

Despite the increased stresses associated with solitary confinement, psychotherapy and access to medications were limited.

Solitary Confinement Created New Mental Health Illnesses

Research has shown that solitary confinement can exacerbate, cause a relapse, or lead to the development of new mental health conditions. "Security Housing Unit (SHU) Syndrome" is a term coined to describe symptoms resulting from stays in solitary confinement consisting of hyperresponsiveness to basic stimuli, delusions and hallucinations, panic attacks, and obsessional thoughts, paranoia, and impulse control.[153]

Our findings suggest that solitary confinement not only provided inadequate mental health care for those with existing mental health conditions, but also led to the development of new symptoms (with possible new diagnoses) for others. Of the 15 people who required care for a mental health condition during solitary confinement, 10 (67 percent) had new symptoms that developed during solitary confinement. The most commonly reported issues were anxiety (n=5) and depression (n=5), followed by PTSD, disassociation, and claustrophobia.

Depression was commonly reported, which interviewees attributed to forced prolonged loneliness and the prohibition of visitors or meaningful activities. One participant described wanting to "scream and cry" from not having visitors and not having anyone to speak with (32-year-old agender person, Etowah County Jail). Multiple participants noted that while regular detention was also demoralizing, the lack of access to books, video entertainment, and socialization opportunities drove their depression. Solitary confinement even led to suicidal thoughts.

> " I ended up losing my mind for two weeks, even talking to myself. I thought about suicide. I still have those thoughts in Senegal."
> *34-year-old man, Bristol County Correctional Facility*

Solitary confinement also drove other serious mental health conditions in detained people, including psychosis, dissociation, and obsessive-compulsive tendencies; many participants reported that these symptoms were not present prior to solitary confinement. Participants shared many different types of psychosis-related symptoms, including amnesia, delusions, and hallucinations. These conditions could also manifest in self-harming behaviors such as one person who hit himself repeatedly with a cable, and another who felt so "crazy that I kept banging my head on the door," which he perceived was the only way he would be able to see a mental health provider (30-year-old man, Kandiyohi County Jail).

"Being in solitary [confinement], that is like a whole other level of playing with your mind. To bother you, to hurt you, to offend you, to make you feel like less than nothing. Even your biology changes, how you view the world changes … your mind and your body break into little pieces."

50-year-old man, Northwest ICE Processing Center

Key Findings

continued

Long-term Harms of Solitary Confinement
Solitary confinement not only affected people during their detention stays, but also created lasting impacts that followed them after decarceration. When asked how their time in solitary impacted their lives presently, many people discussed how they now have increased anger, fear of authority figures, and trouble socializing.

"Sometimes I feel like someone's following me and I'm afraid they'll take me to solitary confinement. Sometimes I'll wake up and think that I'm in solitary confinement. I'll have to look out of the window to remind myself I'm not there. I still have the same nightmares I did while in solitary confinement."

33-year-old man, Caroline Detention Center

Several participants noted persistent symptoms of anxiety, agoraphobia, and recurrent nightmares. One person felt "a lot of anxiety right after solitary confinement, and couldn't stop crying all the time," which eventually led to an eating disorder (30-year-old woman, Irwin County Detention Center). Another reported continued claustrophobia whenever he is in elevators where he feels like he is "without oxygen like I can't breathe" (36-year-old man, River Correctional Center). And yet another felt like the enforced boredom in solitary confinement led to persistent obsessive-compulsive tendencies, describing how

> "I used to rearrange stuff in my cell … and just cleaning, cleaning. There was nothing to do, so cleaning would kill time. Now I do the same thing."
> *30-year-old man, Kandiyohi County Jail*

Participants reported that they sought professional help for their mental health symptoms, with one person stating that he now suffers from "chronic PTSD, anxiety, and depression" (56-year-old man, Buffalo (Batavia) Service Processing Center).

Graphic 14: Impacts on Mental Health from Solitary Confinement

Claustrophobia
"I still don't like to be in confined spaces like a room or bathroom."

Agoraphobia
"I initially struggled to leave the house."

Paranoia
"I feel like someone's following me and I'm afraid they'll take me to solitary confinement."

Insomnia
"I wasn't able to sleep."

Hyperarousal
"Anytime I heard the door, my heart would start beating faster, like I was having a panic attack."

Mood Changes
"[I] easily get angry, everything upsets me, and I feel aggressive."

Pervasive Humiliation and Violence

Solitary confinement was also associated with experiences of cruel, inhuman, or degrading treatment for many of the people interviewed. Twelve people (46 percent) said they experienced some form of verbal abuse, harassment, or physical violence while in solitary confinement by immigration detention staff.

Verbal abuse was the most common form of harassment reported, and commonly included racist or homophobic statements. One interviewee, who identifies as agender, was harassed by staff for being perceived as too feminine:

> " they called me slurs like f*ggot ("maricón"), bird ("pájaro"), b*tch ("puto") that you call gay people."
> *32-year-old agender person, Etowah County Jail*

Similarly, a detained person who identified as LGBTQIA+, described hearing threatening statements:

> " in segregation, I was asked by the guards to 'suck my d**k, you b***h,' or perform oral sex on them."
> *56-year-old man, Buffalo (Batavia) Service Processing Center*

Another interviewee experienced similar verbal prejudice based on race:

> " They [facility staff] made fun of me for not speaking English. They gave me the finger and spit at me. They said I was a thief and would make the country worse because I was Black."
> *29-year-old man, unknown center in Louisiana*

Interviewees reported physical violence and sexual misconduct by facility staff. Strip searches could happen in front of multiple guards and other detained people. One participant who had experienced a sexual assault discussed how being forced to undress in front of others led to a worsening of his anxiety (50-year-old man, Northwest ICE Processing Center). Individual privacy rights were unprotected, as one person said that while he was in solitary confinement, the

> " guard came in while I was showering and stared at me. When I complained, they charged me, they made me stay in solitary confinement longer."
> *33-year-old man, Caroline Detention Facility*

Two participants described being filmed or photographed while naked, with one stating that

> " they [facility staff] tied up my feet and hands. They took pictures of me naked. They brought a camera and filmed in the bathroom with five or six officials in the bathroom."
> *37-year-old man, Orange County Jail*

People Held in Solitary Confinement Are Punished for Complaining

Many study participants spoke out about injustices related to solitary confinement via formal and informal channels but were faced with retaliation instead of change. The participants commonly did so through filing written complaints, communicating with their lawyers, or participating in hunger strikes.

In response, 12 people (67 percent) who reported issues related to solitary confinement faced some sort of punishment for their actions. The most common form of retaliation was an extension of solitary confinement (five people), followed by physical abuse such as pepper spray (three people), and verbal abuse (three people). One study participant was notably refused necessary accommodations for his religion – such as being denied a prayer rug and given non-halal meals – as punishment for his speaking out about the living conditions in solitary confinement (30-year-old man, Kandiyohi County Jail).

Legal and Policy Framework

The U.S. Government Must Safeguard the Lives of Immigrants in Detention

Immigrants in detention are protected under the Fifth Amendment of the U.S. Constitution, which mandates that no person shall be "deprived of life, liberty, or property, without due process of law."[154] The Due Process Clause extends to "all 'persons' within the United States," regardless of their immigration status and guarantees immigrants held in civil detention the right to be free from punitive conditions of confinement.[155] Under the Due Process Clause, the government has an obligation to protect the health and safety of people in civil immigration detention and to provide for their basic needs, including food and medical care.[156] The U.S. Supreme Court has recognized that people must be afforded greater constitutional protections and more considerate treatment in civil confinement than in criminal custody because civil confinement is – at least in theory – not intended to be punishment.[157]

Additionally, retaliation against immigrants who protest the use and misuse of solitary confinement or report issues with detention conditions violates basic First Amendment rights under the U.S. Constitution.[158] Furthermore, the facilities' failures to accommodate people's free exercise of religion while in immigration detention is a violation of basic First Amendment rights.[159]

Agency guidelines set forth specific procedures that detention centers must follow when placing immigrants in solitary confinement. ICE issued the 2013 ICE "Segregation Directive" to supplement preexisting detention standards, including the National Detention Standards (NDS) and the Performance Based National Detention Standards (PBNDS), that detention centers are obligated to follow.[160] ICE has periodically revised these standards to address safety-related concerns, including the use of solitary confinement and the provision of proper medical care.[161] In the 2019 NDS, ICE significantly weakened standards.[162] Furthermore, the required standards vary by facility as the terms in the individual contracts are set between ICE and each facility.[163] The 2013 "Segregation Directive," however, sets the minimum standards that apply in all facilities.

Prolonged Solitary Confinement and the Solitary Confinement of People with Mental Health Conditions Constitutes Torture Under International Law

Under international law, detention of immigrants – especially holding them in solitary confinement – should be used only for limited purposes and as a last resort.[164] Arbitrary and unlawful detention is prohibited under the International Covenant on Civil and Political Rights (ICCPR), which the United States has ratified, and the UN Human Rights Committee has emphasized that detention of people seeking asylum must be subject to periodic review and that any detention of immigrants beyond a brief period must take into account alternatives to detention and impact on health.[165] The UN High Commissioner for Refugees Executive Committee has also noted that people seeking asylum should only be detained in limited circumstances to verify identity or travel documents, make preliminary assessments of claims, or based on an individualized risk and security assessment.[166] Yet the United States consistently flouts these international standards, detaining thousands of immigrants every day in inhuman conditions, including in solitary confinement for prolonged periods of time.

The UN Special Rapporteur on Torture and the UN Human Rights Committee have long recognized that prolonged solitary confinement may constitute torture or cruel, inhuman, or degrading treatment.[167] Under the UN Standard Minimum Rules for the Treatment of Prisoners (known as the Nelson Mandela Rules), prolonged solitary confinement – defined as confinement in excess of 15 days – is specifically prohibited.[168] Additionally, the UN Special Rapporteur on Torture has repeatedly emphasized that such prolonged solitary constitutes torture.[169] The Special Rapporteur has highlighted the debilitating effects of solitary confinement on people with mental health conditions, stating that "individuals with mental disabilities should never be subjected to solitary confinement."[170]

The United States is subject to the absolute prohibition of torture under international law by having ratified the UN Convention Against Torture.[171] Despite these international obligations, the country continues to subject immigrants to torture and cruel, inhuman, and degrading treatment through the misuse of solitary confinement.

Indeed, when surveying detention conditions in the United States, the UN Special Rapporteur on Torture has cited numerous concerns about the country's routine use of solitary confinement.[172] The former Special Rapporteur on Torture Nils Melzer explained in 2020 that the impact of such confinement includes "severe and often irreparable psychological and physical" harm, ranging from "progressively severe forms of anxiety, stress, and depression to cognitive impairment and suicidal tendencies."[173] The Special Rapporteur concluded that such "deliberate infliction of severe mental pain or suffering may well amount to psychological torture."[174] Regional human rights bodies such as the Inter-American Commission on Human Rights have also cited the "deeply troubl[ing]" use of solitary confinement in U.S. immigration detention, particularly "in the case of vulnerable immigration detainees, including members of the LGBT community."[175]

Most recently, in November 2023, the UN Human Rights Committee, which monitors state compliance with the International Covenant on Civil and Political Rights, published its concluding observations on the fifth periodic report of the United States, in which it stated that the use of solitary confinement for "juveniles and persons with intellectual or psychosocial disabilities" in prison should be prohibited.[176] Regarding immigration detention, the Committee expressed grave concern over the prolonged use of solitary confinement for the treatment of immigrants, including refugees and people seeking asylum.[177]

ICE's failures to follow domestic and international laws as well as its own guidance have created dangerous conditions for people who are detained – particularly those with mental health conditions and medical conditions, with no recourse to protect themselves from life-threatening harm due to the misuse of solitary confinement.

Conclusion and Recommendations

ICE's pervasive use of solitary confinement – across over one hundred facilities at state and local levels – is alarmingly widespread and profoundly disturbing. This research, corroborated by findings from myriad sources, including the DHS Office of Inspector General and the U.S. Government Accountability Office, reveals the persistent and prolonged use of solitary confinement by ICE; the harmful, long-lasting impact on those exposed to such isolation; and the ongoing lack of meaningful oversight and accountability for violations of law and policy.

Over 10 years ago, PHR, with the National Immigrant Justice Center, co-authored a seminal report on the use of solitary confinement in immigration detention centers. Since then, despite countless intervening and damning investigations, there has been no improvement: U.S. immigration detention remains inappropriately carceral and punitive, and solitary confinement is routinely used in a manner that meets the definition of torture, or to cruel, inhuman, or degrading treatment according to international human rights law. As stated by one DHS whistleblower, ICE uses solitary confinement as a "first and only option,"[179] rather than as a last resort, as required by ICE policy and guidelines as well as international law.

The persistent lack of oversight and accountability related to the use of solitary confinement in immigration detention has not only allowed abuses to continue unabated, but in fact to intensify over the past decade. The devolution in care for people in detention has resulted in egregious breaches of international and domestic law, foundational principles of the U.S. Constitution, and ICE's own directives.

In the last five years alone, ICE placed people in solitary confinement over 14,000 times, including those with preexisting mental health conditions and other vulnerabilities. Lasting nearly a month on average and sometimes for over two years, this persistent application of solitary confinement illustrates how concerns repeatedly raised by members of Congress, government auditors, and whistleblowers alike have been consistently ignored. The disproportionately harmful impact of solitary confinement on vulnerable populations, particularly transgender people and those with mental health and medical conditions, indicates a pattern of systemic discrimination and neglect that contravenes ICE's own policies.

ICE's use of the "Segregation Review Management System" to monitor solitary confinement placements is deeply flawed, as evidenced by incomplete and erroneous data collection, faulty analysis, and the lack of accountability revealed in this report. These findings raise serious questions about the reliability and efficacy of the system's quality assurance and reporting accuracy.

The evidence of profound and lasting physical and mental health deterioration in people subjected to solitary confinement demands an immediate end to DHS's use of this practice. **There is overwhelming evidence and consensus that efforts at modest reforms such as improving data collection, retention and reporting, have done little to stop human rights violations in ICE detention.**

The recommendations below serve as a road map for DHS to completely phase out the use of solitary confinement in ICE detention. Congress and state and local entities, as well as international bodies, must also advocate for the end of solitary confinement, as outlined below.

1. **Publicly commit to ending the use of solitary confinement in all immigration detention facilities.** As it abandons solitary confinement, DHS and ICE must express this commitment in the form of a binding directive. The directive should:
   - **Require a presumption of release from ICE detention for people who have reported existing vulnerabilities**, including, but not limited to, people with serious medical conditions, mental health conditions, disabilities, LGBTQIA+ people, and survivors of torture and/or sexual violence. These people should be released into the safety of their community with post-release care plans in place per the 2022 ICE directive, in addition to providing resources and referrals for social, legal, and/or medical services as appropriate.
   - **Mandate that any person in detention be afforded 24-hour access to qualified mental and medical health care professionals** who respond in a timely manner and in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
   - **Require increased transparency from ICE's Detention Monitoring Council** by making properly (redacted or deidentified) reports and reviews related to solitary confinement publicly available on the agency's website within 72 hours.

2. **Amend the 2013 "Segregation Directive" to ensure that every ICE detention facility, public or privately contracted, is required to report concurrently to ICE Field Office Directors and ICE headquarters within 24 hours of placing someone in solitary confinement.** ICE headquarters, in turn, must share this consolidated "segregation"/solitary confinement data with the DHS Office of the Secretary within 72 hours. This requirement must apply to every confined person, regardless of the duration of their confinement or whether they have a vulnerability. Additionally:
   - For those who are **currently** in solitary confinement, require a prompt and meaningful psychosocial and medical evaluation, undertaken by qualified medical professionals, who can assess the prevalence and extent of existing vulnerabilities.
   - For those scheduled for placement in solitary confinement, require a meaningful psychosocial and medical evaluation by qualified medical professionals who can assess the prevalence and extent of existing vulnerabilities prior to such a placement.
   - Mandate the reporting of race and ethnicity of each person in solitary confinement.
   - Mandate the reporting of the justification provided for initial confinement; justification for continued confinement; duration of the confinement; any vulnerabilities identified; and a detailed description of the alternatives to solitary confinement that were considered and/or applied, as listed in 5.3.(2) of the 2013 ICE "Directive on Segregation."
   - Require daily checks and regular monitoring and documentation by qualified and licensed health care professionals against a detailed checklist created in partnership with independent medical professionals, that includes reviewing vital signs, checking for signs of self-harm and any other indicators of deteriorating mental and physical health.
   - Require the routine sharing by ICE of deidentified data acquired through the above reporting measures on its website every two weeks as part of its release of Detention Statistics, until it has ended the use of solitary confinement.

3. **Revise current contracts and agreements with immigration detention facilities providers and contractors to include stringent performance standards and clear metrics for compliance regarding the use of solitary confinement. Compliance should be assessed through regular and comprehensive inspections by the Contracting Officer.** Additionally, to increase adherence to detention standards, ICE must:
   - Introduce a performance-based contracting model, where a portion of payment is contingent upon meeting certain performance and reporting indicators, including those listed in recommendations 1 and 2 herein; and
   - Impose immediate financial penalties for any violation of performance and reporting indicators, and contract termination for repeated or persistent violation.

4. **Establish a task force led by the Office of the Secretary of DHS to develop a comprehensive plan, including specific recommendations for phasing out the use of solitary confinement.** The task force must include:
   - Members with knowledge of, or expertise regarding, the mental and physical health consequences of the use of solitary confinement;
   - Independent medical experts;
   - Independent subject matter experts from civil society (including those with expertise in the use of solitary confinement in criminal and civil custodial settings and human rights);
   - Formerly detained immigrants who have experienced solitary confinement in ICE custody; and
   - Employees of the following offices:
     - Civil Rights and Civil Liberties (CRCL);
     - ICE Health Services Corps (IHSC);
     - Immigration Detention Ombudsman (OIDO);
     - Enforcement and Removal Operations (ERO); and
     - Office of Professional Responsibility (OPR).

   The plan must be presented to Congress and publicly accessible on ICE's website upon completion, which shall be no later than one year after formation of the task force. Finally, recommendations included in the plan should ensure the end of ICE's use of solitary confinement in immigration detention within one year of presentation of the plan to Congress and the public.

5. Strengthen and expand the duties of the Office for Civil Rights and Civil Liberties to include integrating civil rights and civil liberties protections into all DHS programs and activities. Additionally, require that CRCL **establish and publicize a system for staff and people detained in immigration detention facilities to file grievances about solitary confinement** without fear of retaliation. Further, make complaints filed available to the public and accessible online, redacting identifying information from those who have requested confidentiality. CRCL's recommendations to ICE based on these grievances or any related inspections or evaluations must be regarded as compulsory, rather than optional, and subject to continuous monitoring and oversight to ensure full implementation of the recommendations.

Conclusion and Recommendations

continued

To the U.S. Congress:

6. **Pass binding legislation banning the use of solitary confinement in immigration detention** and legislation that will significantly decrease the number of people in immigration detention, including the End Solitary Confinement Act (H.R. 4972 / S.3409) and Dignity for Detained Immigrants Act (H.R. 2760 / S.1208).

7. **Pass binding legislation that strengthens and expands CRCL's functions and authority,** such as the Department of Homeland Security Office for Civil Rights and Civil Liberties Authorization Act (H.R. 4713).

8. **Use funding bills to incentivize the end of solitary confinement and adopt community-based alternatives to ICE detention** that are not funded by an enforcement agency such as ICE or CBP, are not surveillance-based, and that are contracted to community-based, civil society, and nonprofit organizations.

9. **Conduct semiannual public hearings to hold DHS and ICE accountable** for its use of solitary confinement in immigration detention, and track progress against the implementation of the recommendations herein.

10. **Ratify the Optional Protocol to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** as a matter of priority to allow independent monitoring of all places of detention in the United States.

To State Governors and State Attorneys General:

11. End contracts with facilities that use solitary confinement in immigration detention.

12. Encourage states to pass legislation establishing state attorney general oversight of ICE detention facilities and prohibiting local governments from expanding or entering into contracts with the federal government or private companies for immigration detention.

The U.S. President must:

13. **Sign the Optional Protocol to the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.**

14. **End solitary confinement** and take steps to operationalize this prohibition in immigration custody.

To the UN Special Rapporteur on Health, the UN Special Rapporteur on Torture, the UN Committee Against Torture, the UN Human Rights Committee, the UN Working Group on Enforced or Involuntary Disappearances, and the UN Working Group on Arbitrary Detention:

15. Request an unconditional country visit to the United States and monitor conditions of immigration detention, including use of solitary confinement, as soon as possible.

16. Assess U.S. compliance with the UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and where necessary, make recommendations for reform.

17. Raise concern about the U.S. government's use of solitary confinement in immigration detention facilities in the context of its regular dialogue with U.S. authorities and urge its abolition.

Appendix A. Interview Questionnaire

Section 1. Demographics

Basics

- How old are you?

- What gender do you identify with?
  - Male
  - Female
  - Nonbinary
  - Trans Male
  - Trans Female
  - Other (please describe)

- What country or countries did you live in before coming to the United States?

- What language or languages are you most comfortable speaking?

- During your time in detention, how comfortable did you feel reading English?
  - Very Comfortable
  - Comfortable
  - Neutral
  - Uncomfortable
  - Very Uncomfortable

- During your time in detention, how comfortable did you feel understanding and speaking English?
  - Very Comfortable
  - Comfortable
  - Neutral
  - Uncomfortable
  - Very Uncomfortable

- Which best describes your race (may select multiple)?
  - White
  - Black
  - Asian
  - Pacific Islander
  - Other (please describe)

- Do you identify as being Hispanic, Latinx, or Spanish origin?
  - Yes
  - No
  - Unknown

- Do you identify as being a part of an indigenous group?
  - Yes
  - No
  - Unknown

Detention Centers Stay

- Were you ever transferred between different detention centers?
  - Yes
    - What were the names of each center you were at?
    - When were you at each detention center? If you don't know the exact dates, please estimate.
  - No
    - What was the name of the detention center you were at?
    - When did you enter detention? If you don't know the exact date, please estimate.
    - When were you released from ICE detainment? If you don't know the exact date, please estimate.
  - Don't Know

Identification with Vulnerable Groups

- Do you identify as lesbian, gay, bisexual, transgender, or queer?
  - Yes
    - What do you identify as?
  - No
  - Don't Know

- Did you have any medical conditions during your time in detention (for example: high blood pressure, diabetes)?
  - Yes
    - What condition(s) do you have?
  - No
  - Don't Know

- Did you have any mental health conditions during your time in detention (for example: anxiety, depression)?
  - Yes
    - What condition(s) do you have?
  - No
  - Don't Know

- Do you have any mental health conditions now, after your time in detention (for example: anxiety, depression)?
  - Yes
    - What condition(s) do you have?
  - No
  - Don't Know

- Did you have a disability during your time in detention (for example: trouble with hearing, vision)?
  - Yes
    - What condition(s) do you have?
  - No
  - Don't Know

Appendix A. Interview Questionnaire

continued

- Were you ever pregnant or breastfeeding during your time in detention?
  - Yes
    - Were you ever pregnant or breastfeeding when you were placed in solitary confinement?
      - Yes
      - No
      - Don't know
  - No
  - Don't Know

Stays in Solitary Confinement

- How many times were you placed in solitary confinement?

- *Only if the participant reported being in multiple locations*: Which detention center(s) were you in when you were placed in solitary confinement?

- *Ask for the last instance of solitary confinement*: What was the total length of time you were in solitary confinement for that particular stay? If you don't know the exact days, please estimate.

- Why do you think you were taken to solitary confinement (mark appropriate category and open-ended)?
  - Disciplinary "segregation"
    - Did you ever have an official hearing about this incident?
      - Yes
      - No
      - Don't know
  - Protective custody
    - Did you ask to be placed in protective custody?
      - Yes
      - No
      - Don't know
  - Suicide risk
  - Hunger strike
  - Medical isolation
    - For what condition were you placed in solitary confinement for?
  - Transfer to Other (please describe) unit/center
  - Victim of sexual assault
  - Other (please describe)

Section 2. Questions on Conditions in Solitary Confinement

Setting in Solitary Confinement

- How many hours in a day did you stay in the solitary confinement room?

- How often did someone check on you while in solitary confinement?
- How did they check on you?

- Who was it (can select multiple)?
  - Guard
  - Medical professional
  - Supervisor
  - Other (please describe)
  - Don't Know

- On average, how many meals were you given a day while you were in solitary confinement?

- Were these meals the same as a normal meal in the detention center?
  - Yes
  - No
    - How were the meals different than in the general detention center population?
  - Don't Know

- On average, how many times a week were you allowed to shower while you were in solitary confinement?

- Can you describe the room where you were in solitary confinement? (For example, describe the furniture, window, how long the lights were on/off, access to a toilet.)

- Were the mattress and bedding in solitary confinement the same as in the detention center?
  - Yes
  - No
    - How were the mattress and bedding different than in the detention center?
  - Don't Know

Access to Medical/Mental Health Care

- Were you evaluated by a health care professional before you were placed in solitary confinement?
  - Yes
    - Did they ask you about any existing mental health issues?
      - Yes
      - No
      - Don't Know
    - Did they ask you about any prior suicide attempts or self-harm?
      - Yes
      - No
      - Don't Know
    - Did they ask you about your medical needs?
      - Yes
      - No
      - Don't Know
    - No
    - Don't Know

- Were you routinely evaluated by a health care professional while you were in solitary confinement?
  - Yes
    - How often did a health care professional see you while you were in solitary confinement?
    - What kind of health care professional saw you while you were in solitary confinement?
      - Physician
      - Physician's Assistant
      - Nurse
      - Other (please describe)
  - No
  - Don't Know

- Did you have a medical condition requiring care while you were in solitary confinement?
  - Yes
    - Was it for a new medical condition or one you had before solitary confinement?
    - What was it for?
    - Did you put in a request to see a medical provider?
      - Yes
        - How long did you have to wait to see a medical provider after you put in a request?
        - What kind of health care professional saw you while you were in solitary confinement?
          - Physician
          - Physician's Assistant
          - Nurse
          - Other (please describe)
      - No
      - Don't Know
    - No
    - Don't Know

- Did you need any medications while you were in solitary confinement (either for chronic conditions or new medications)?
  - Yes
    - Were you provided your medications while you were in solitary confinement?
      - Yes
      - No
        - How long were you not provided your medications for?
      - Don't Know
    - No
    - Don't Know

- Did you have a mental health condition requiring care while you were in solitary confinement (for example: anxiety, depression, schizophrenia)?
  - Yes
    - Was it for a new mental health condition or one you had before solitary confinement?
    - What was it for?
    - Did you put in a request to see a mental health provider?
      - Yes
        - How long did you have to wait to see a mental health provider after you put in a request?
        - What kind of health care professional saw you while you were in solitary confinement?
          - Physician
          - Physician's Assistant
          - Nurse
          - Therapist
          - Other (please describe)
      - No
      - Don't Know
    - No
    - Don't Know

Appendix A. Interview Questionnaire

continued

Access to Services

- Were you ever given a piece of paper explaining why you were being placed in solitary confinement?
  - Yes
  - No
  - Don't Know

- Were you told how much longer you were going to be in solitary confinement?
  - Yes
    - Were you given different estimates of how much longer you were going to be in solitary confinement?
      - Yes
        - How did this estimate change?
          - Increase
          - Decrease
          - Don't Know
      - No
      - Don't Know

- *Only if participant mentioned not being comfortable communicating in English*:
  Were you provided interpreter or translation services in solitary confinement?
  - Yes
    - How was the translation provided?
      - Bilingual staff
      - Telephone interpreter
      - In–person interpreter
      - Other (please describe)
    - How often was the translation provided?
      - Always
      - Often
      - Sometimes
      - Rarely
      - Never
  - No
  - Don't Know

- Did a supervisor ever interview you while you were in solitary confinement?
  - Yes
  - No
  - Don't Know

- Were you allowed to use a telephone while in solitary confinement?
  - Yes
    - Were there any restrictions on how you could use the telephone?
      - Yes
        - How were you restricted from using the telephone?
      - No
      - Don't Know
  - No
  - Don't Know

- Were you able to use any other forms of communication (like tablets, WhatsApp, or video calls)?
  - Yes
    - What other forms of communication were you allowed to use?
    - Were there any restrictions on how you could use these forms of communication?
      - Yes
      - No
      - Don't Know
  - No
  - Don't Know

- Were you provided a list of legal resources while in solitary confinement (for example, phone numbers of lawyers)?
  - Yes
  - No
  - Don't Know

- Were you able to talk to lawyers or get legal help while in solitary confinement?
  - Yes
    - How were you able to talk to your lawyers?
      - Telephone call
      - Zoom
      - WhatsApp
      - Text messages
      - Other (please describe)
  - No
    - How were you prevented from getting legal help?
  - Did Not Try
  - Don't Know

- How often were you able to write, send, and receive letters while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know
    - *If Always/Often/Sometimes/Rarely above*: Was the content of your mail kept private while in solitary confinement?
      - Yes
      - No
        - How was your mail not kept private?
      - Don't Know
    - *If Often/Sometimes/Rarely/Never above*: How were you prevented from communicating via letters with others, if any?

- How often were you able to participate in religious practices while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know
    - *If Often/Sometimes/Rarely/Never above*: How were you prevented from participating in religious practices, if any?

- How often were you allowed to have at least one hour of recreation per day while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know
    - *If Often/Sometimes/Rarely/Never above*: Were you provided with a written notification why you were not able to have recreation?
      - Yes
      - No
      - Don't Know

- How often were you able to use the visiting room while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know

- How often were you able to use the commissary while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know

- How often were you able to use the library while in solitary confinement?
  - Always
  - Often
  - Sometimes
  - Rarely
  - Never
  - Did Not Try
  - Don't Know

Appendix A. Interview Questionnaire

continued

Section 3. Questions on Experiences of Solitary Confinement and Abuse

Experience in Solitary Confinement

- What do you remember about your time in solitary confinement?

Punishment and Retaliation

- Have you ever been a victim of sexual assault, torture, trafficking, or abuse before your time in detention?
  - Yes
  - No
  - Don't Know

- Did you experience any verbal abuse, harassment, or physical violence while in solitary confinement? If so, please describe.

- Did you ever report or protest any issues related to solitary confinement?
  - Yes
    - What did you do? (can select multiple)
      - Verbally complained to a guard or staff
      - Filed a written complaint through the facility grievance procedure
      - Went on a hunger strike
      - Sent a message to a family member and asked to publicize it; Spoke with the media
      - Told an attorney
      - Other (please describe)
    - Did you face retaliation for your actions? (can select multiple)
      - Verbal abuse
        - If yes, what happened?
      - Physical abuse
        - If yes, what happened?
      - Extension of solitary confinement
        - If yes, how much longer were you placed in confinement?
      - Pepper spray
      - Transferred to another facility
      - Other (please describe)

Impact

- How did you feel during your transition out of solitary confinement?

- Was your mental health impacted because of solitary confinement? If so, how?

- Was your medical health impacted because of solitary confinement? If so, how?

- Has solitary confinement impacted your life now in any ways? If so, how?

Reflections on Solitary Confinement

- What changes, if any, do you think should be made about solitary confinement?
- Is there anything else you would like to share that we did not talk about?

Appendix B. Countries of Origin and Languages Spoken by Participants

Country of Origin, n, Percent of Participants		Language, n, Percent of Participants	
Mexico	8 (30.8%)	Spanish	16 (61.5%)
Honduras	3 (11.5%)	English	13 (50.0%)
Colombia	5 (19.2%)	French	3 (11.5%)
Liberia	2 (7.7%)	Arabic	1 (3.8%)
Ivory Coast	2 (7.7%)	German	1 (3.8%)
Italy	2 (7.7%)	Italian	1 (3.8%)
Cuba	1 (3.8%)	Krahn	1 (3.8%)
England	1 (3.8%)	Russian	1 (3.8%)
Germany	1 (3.8%)	Somali	1 (3.8%)
Ghana	1 (3.8%)	Turkish	1 (3.8%)
Jamaica	1 (3.8%)	Ukrainian	1 (3.8%)
Kenya	1 (3.8%)	Wolof	1 (3.8%)
Poland	1 (3.8%)		
Republic of Guinea	1 (3.8%)		
Senegal	1 (3.8%)		
Somalia	1 (3.8%)		
Tunisia	1 (3.8%)		
Turkey	1 (3.8%)		
Ukraine	1 (3.8%)		

Please note that percentages do not add up to 100% because people may have come from several different countries or speak several different languages.

Endnotes

1. Eunice Cho, "Unchecked Growth: Private Prison Corporations and Immigration Detention, Three Years Into the Biden Administration," last modified August 7, 2023, https://www.aclu.org/news/immigrants-rights/unchecked-growth-private-prison-corporations-and-immigration-detention-three-years-into-the-biden-administration.
2. ICE Detainees, TRAC Reports, Inc., https://trac.syr.edu/immigration/detentionstats/pop_agen_table.html.
3. See Inter-American Commission on Human Rights, "Report on Immigration in the United States: Detention and Due Process," December 30, 2010; Jean Casella and James Ridgeway, "FAQs," Solitary Watch, http://solitarywatch.com/facts/faq. [hereinafter FAQs, SOLITARY WATCH].
4. HLS FOIA: Spreadsheet Showing Solitary Confinement Stays Between September 4, 2018, and September 13, 2023, released by ICE on October 16, 2023 [hereinafter HLS FOIA: Spreadsheet]. The spreadsheet was produced in the midst of FOIA litigation, and at the time HIRCP wrote this report, HIRCP was still waiting for ICE to produce a more complete version of the spreadsheet as required by court order. See Harvard Immigr. and Refugee Clinical Program v. U.S. Department of Homeland Sec., 21-cv-12030, 2023 WL 4685961, (D. Mass. July 21, 2023).
5. HLS FOIA: Spreadsheet.
6. DHS OIG, "ICE Needs to Improve its Oversight of Segregation Use in Detention Facilities," October 13, 2021, https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf.
7. The United Nations Standard Minimum Rules for the Treatment of Prisoners, Rule 44 (2015) (https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf (defining solitary confinement as confinement for 22 hours or more a day without meaningful human contact."
8. DHS OIG, "ICE Needs to Improve its Oversight of Segregation Use in Detention Facilities."
9. Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature," 2006, Crime and Justice, 34(1), 441–528, https://doi.org/10.1086/500626; See also United Nations, "Special Rapporteur on Torture Tells Third Committee Use of Prolonged Solitary Confinement on Rise, Calls for Global Ban on Practice," Oct. 18, 2011, https://www.ohchr.org/en/press-releases/2011/10/un-special-rapporteur-torture-calls-prohibition-solitary-confinement.
10. Peter Scharff Smith, "The Effects of Solitary Confinement on Prison Inmates" 337, 441–528.
11. Brinkley-Rubinstein L, Sivaraman J, Rosen DL, et al. "Association of Restrictive Housing During Incarceration with Mortality After Release," JAMA Network Open 2019;2(10):e1912516. doi:10.1001/jamanetworkopen.2019.12516.
12. New York Civil Liberties Union, "Boxed in: The True Cost of Extreme Isolation in New York's Prisons" at 44, October 2, 2012, https://www.nyclu.org/sites/default/files/publications/nyclu_boxedin_FINAL.pdf; NIJC & PHR, "Invisible in Isolation" at 13-14, https://immigrantjustice.org/sites/immigrantjustice.org/files/Invisible%20in%20Isolation-The%20Use%20of%20Segregation%20and%20Solitary%20Confinement%20in%20Immigration%20Detention.September%202012_7.pdf; Stuart Grassian, "Psychiatric Effects of Solitary Confinement," 22 WASH. U. J. L. & POL'Y 325 (2006) at 347-48, https://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24; Jose Olivares, "ICE Detainee Diagnosed with Schizophrenia Spent 21 Days in Solitary Confinement, Then Took His Own Life," July 27, 2018, https://theintercept.com/2018/07/27/immigrant-detention-suicides-ice-corecivic/.
13. Erfani et al, full reference available at: https://pubmed.ncbi.nlm.nih.gov/33575408/ (noting increased suicide rate in detention facilities); Terp et al, full reference available at: https://pubmed.ncbi.nlm.nih.gov/33575408/.
14. United Nations, "Special Rapporteur on Torture Tells Third Committee Use of Prolonged Solitary Confinement on Rise, Calls for Global Ban on Practice," October 18, 2011, https://www.ohchr.org/en/press-releases/2011/10/un-special-rapporteur-torture-calls-prohibition-solitary-confinement.
15. Ibid.
16. Ibid.
17. U.S. Immigration and Customs Enforcement, 11065.1, "Review of the Use of Segregation for ICE detainees," 2013 at 2, https://www.dhs.gov/sites/default/files/publications/segregation_directive.pdf [hereinafter 2013 ICE Segregation Directive]. Detention facilities across the country often use a range of euphemisms to refer to solitary confinement, including administrative or disciplinary "segregation," special or restrictive housing. FAQs, SOLITARY WATCH.
18. *2013 ICE Segregation Directive* at 2.
19. Ibid.
20. Ibid. at 1.
21. Ibid. at 6.
22. Ibid. at 4, 6.
23. ICE, Mem. from Thomas Homan, "Further Guidance Regarding the Care of Transgender Detainees" at 4, June 19, 2015, https://www.ice.gov/sites/default/files/documents/Document/2015/TransgenderCareMemorandum.pdf.
24. Ibid.
25. U.S. ICE, ICE Directive 11063.2, "Identification, Communication, Recordkeeping, and Safe Release Planning for Detained Individuals with Serious Mental Disorders or Conditions and/or Who are Determined to Be Incompetent by an Immigration Judge," April 5, 2022, https://www.ice.gov/doclib/news/releases/2022/11063-2.pdf.
26. Ibid. at 5.
27. *2013 ICE Segregation Directive* at 6.
28. 28 Ibid. at 4.
29. U.S. Government Accountability Office, *Immigration Detention Actions Needed to Collect Consistent Information for Segregated Housing Oversight*, October 2022, https://www.gao.gov/assets/gao-23-105366.pdf.
30. Ibid. at 20.
31. Ibid.
32. Ibid. at 21.
33. Ibid. at 21–22; see also DHS Office of Inspector General, "ICE Needs to Improve Its Oversight of Segregation Use in Detention Facilities," OIG-22-01, October 13, 2021.
34. U. S. Government Accountability Office, "Immigration Detention Actions Needed to Collect Consistent Information for Segregated Housing Oversight" at 19, October 2022, https://www.gao.gov/assets/gao-23-105366.pdf.
35. See Maryam Saleh and Spencer Woodman, "A Homeland Security Whistleblower goes Public about ICE Abuse of Solitary Confinement," The Intercept, May 2019, https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/; Maryam Saleh, "Whistleblower 'Helpless' to Stop U.S. Immigration Solitary Confinement Abuses," May 2019, International Consortium of Investigative Journalists, https://www.icij.org/investigations/solitary-voices/whistleblower-helpless-to-stop-us-immigration-solitary-confinement-abuses/; Nick Schwellenbach, Mia Stienle et. al, "ISOLATED: ICE Confines Some Detainees with Mental Illness in Solitary for Months," Project on Government Oversight, August 2019, https://www.pogo.org/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months; Spencer Woodman and Maryam Saleh, "40 Percent of ICE Detainees Held in Solitary Confinement have a Mental Illness, New Report Finds," The Intercept, August 2019, https://theintercept.com/2019/08/14/ice-solitary-confinement-mental-illness/; Juan Mendez, Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ¶¶ 21, 26, U.N. Doc. A/66/268 August 5, 2011, https://digitallibrary.un.org/record/710177?ln=enA/66/268 (August 5, 2011), https://digitallibrary.un.org/record/710177?ln=en; Kenneth L. Applebaum, "American Psychiatry Should Join the Call to Abolish Solitary Confinement," 43 J. Am. Acad. Psychiatry L. 406, 408 (2015), http://jaapl.org/content/jaapl/43/4/406.full.pdf; Human Rights Watch, "Do You See How Much I'm Suffering Here?": Abuse against Transgender Women in US Immigration Detention" March 2016, https://www.hrw.org/sites/default/files/report_pdf/us0316_web.pdf [hereinafter Abuse against Transgender Women]; NIJC & PHR, "Invisible in Isolation" at 13-14, https://www.nyclu.org/sites/default/files/publications/nyclu_boxedin_FINAL.pdf.
36. GAO Report, OIG Report, NIJC Policy Brief, https://immigrantjustice.org/research-items/policy-brief-beyond-repair-ices-abusive-detention-inspection-and-oversight-systemACLU; ACLU blog: https://www.aclu.org/news/immigrants-rights/ices-detention-oversight-system-needs-an-overhaul.
37. Maryam Saleh and Spencer Woodman, "A Homeland Security Whistleblower." ("In July 2014, on the advice of ethics counsel, Gallagher sent a detailed memo to then-Deputy Secretary of Homeland Security Alejandro Mayorkas, emphasizing that segregation was not in fact being used as a last resort in many instances, contrary to ICE policy. 'Essentially, where a detainee's behavior or characteristics are perceived to be disruptive, evidence of noncompliance, or a threat to the general population or 'good order' of the facility,' she wrote, 'segregation serves as a default remedy.'"); Memo of Ellen Gallagher, Senior Policy Advisor, Civil Rights Civil Liberties to Alejandro Mayorkas, Deputy Secretary, DHS, re The Use of Segregation for Immigration Detainees, July 23, 2014, https://www.documentcloud.org/documents/5998113-Mayorkas-Memo-07232014.html. Gallagher is a whistleblower who has publicly flagged issues concerning ICE's use of solitary confinement for multiple years. She is represented by the Government Accountability Project.
38. DHS OIG, "Concerns about ICE Detainee Treatment and Care at Detention Facilities," OIG-18-32, December 11,2017, https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf; DHS OIG, "ICE Field Officers Need to Improve Compliance with Oversight Requirements for Segregation of Detainees with Mental Health Conditions,"OIG-17-119, September 29, 2017, https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119- Sep17.pdf.
39. DHS OIG, "ICE Needs to Improve its Oversight of Segregation Use in Detention Facilities," October 13, 2021, https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf.
40. Ibid.
41. GAO Report.
42. Mem. from DHS Office of Civil Rights and Civil Liberties and the Office of General Counsel to ICE, "Retention Memo: Segregation of Individuals with a Mental Health Disability and/or Serious Mental Illness," September 1, 2023, https://www.dhs.gov/sites/default/files/2023-09/23_0901_crcl_retention_memo_to_ice_segregation_mental_health_or_illness_redacted_508.pdf.
43. Ibid.
44. Ibid.
45. Ibid.

46. "Invisible In Isolation: The Use Of Segregation And Solitary Confinement In Immigration Detention," September 20, 2012, https://immigrantjustice.org/research-items/report-invisible-isolation-use-segregation-and-solitary-confinement-immigration.
47. HLS FOIA: Evaluations Conducted by the Department of Homeland Security's Office for Civil Rights and Civil Liberties on ICE Detention Facilities Between 2012 and 2014, released on October 25, 2023 [hereinafter HLS FOIA: CRCL Evaluations].
48. American Immigration Council, "Press Release: Complaint Filed Against ICE As Misuse of Solitary Confinement in Colorado Facility Raises Concerns," July 13, 2023, https://www.americanimmigrationcouncil.org/news/complaint-filed-against-ice-misuse-solitary-confinement-colorado-facility-raises-concerns.
49. Harvard Immigr. and Refugee Program v. U.S. Dep't of Homeland Sec., 21-cv-12030, 2023 WL 4685961, (D. Mass. July 21, 2023).
50. HLS FOIA: Spreadsheet.
51. POGO FOIA: Spreadsheet Showing Solitary Confinement Stays Between January 2016 and May 2018; ICIJ FOIA: Spreadsheet Showing Solitary Confinement Stays Between 2012 and 2017; HLS FOIA: Spreadsheet.
52. HLS FOIA: Spreadsheet. The SRMS dataset included 14,264 cases, including 155 immigrants still in solitary confinement as of September 14, 2023. As these individuals' stays in solitary confinement were still ongoing, they are not reflected in this report's analysis of average length of solitary confinement.
53. HLS FOIA: 2023 Q3 Segregation Metrics from ICE's Detention Monitoring Council's Quarterly Meeting on September 2023, released on October 16, 2023 [hereinafter HLS FOIA: 2023 Q3 Segregation Metrics]; HLS FOIA. The evaluations were conducted between 2012 and 2014 by doctors in response to complaints CRCL received about the adequacy of mental health services.
54. HLS FOIA: CRCL Evaluations.
55. DHS OIG, "ICE Needs to Improve its Oversight of Segregation Use in Detention Facilities," October 13, 2021, https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf.
56. OIG randomly selected a sample of 265 detention files, based on SRMS data. This resulted in 474 individual segregation placements, as some persons in detention were placed in segregation multiple times. Seventy-five of these placements were not required to be reported under ICE's reporting requirements (see footnote 10 in the OIG report), which brings the total number of placements to be compared between SRMS and facilities to 399. Sixty-two placements were missing from the segregation placements that should have been recorded in SRMS according to ICE policy. The OIG report miscalculated the percentage of underreported placements, by including the placements that were not required to be reported, which resulted in a lower percentage.
57. GAO Report.
58. Ibid.
59. Ibid., from 2017 to 2021. 1,436 (out of 5,907) detained immigrants with a mental condition and 3,541 (out of 4,017) detained immigrants with serious mental condition were not reported by SRMS (see Tables 6 and 7, pp. 35–36).
60. ICE Detention Statistics, https://www.ice.gov/detain/detention-management.
61. HLS FOIA: Spreadsheet.
62. Two detention stats excel files were downloaded from the ICE detention management webpage, https://www.ice.gov/detain/detention-management, covering 2022 and 2023 fiscal years (no statistics on vulnerable populations were found in the earlier years). As ICE provides statistics based on federal government's fiscal years (from October 1 to September 30), only aggregate statistics from the first quarter of 2022 to the third quarter of 2023 (October 2022-June 2023) were compared. The 2022 file (https://www.ice.gov/doclib/detention/FY22-detentionStats.xlsx) was used to obtain statistics for the first three quarters in 2022, and the 2023 file (https://www.ice.gov/doclib/detention/FY23_detentionStats.xlsx) was used to obtain statistics thereafter. These publicly available files reported a total of 2,314 placements of vulnerable populations during the observed seven quarters. As ICE's publicly shared statistics are not disaggregated by type of vulnerability (for example, mental illness, disability, suicide, and so on), necessary restrictions were made to construct aggregates comparable to the ICE's quarterly statistics. According to the downloaded excel files, vulnerable population includes "reported facility-initiated segregation placements of noncitizens that self-identify as lesbian, gay, bisexual, transgender, and/or intersex (LGBTI); have a serious mental or medical illness; are conducting a hunger strike; or are on suicide watch." 7,421 observations from 14,264 were removed to restrict the FOIA-obtained SRMS data to confinements placed from October 1, 2021 to June 30, 2023. Restricting the data to facility-initiated placements, dropped an additional 2,978 placements, resulting in a final sample of 3,865.
63. FOIA-obtained SRMS variables indicating vulnerability were used to count 1,201 placements (variables included were *MentalIll, SeriousMedicalIllness*, *SeriousDisability* and *SuicideRisk*). There were an additional 706 placements that were not identified as vulnerable with any of the above-mentioned variables, but a reason for placement was coded as "Medical/Mental." Without additional information on the severity of medical illnesses for these placements, it cannot be determined if ICE was required to report them as vulnerable. Therefore, assuming these cases were vulnerable could introduce bias. Even if, however, we assume that all these additional placements included vulnerable immigrants, the number of placements in our FOIA dataset was consistently underreported anywhere from 8 to 34 percent per quarter.
64. HLS FOIA: Spreadsheet and ICE Detention Statistics, https://www.ice.gov/detain/detention-management.
65. HLS FOIA: Spreadsheet and ICE Detention Statistics, https://www.ice.gov/detain/detention-management.
66. HLS FOIA: CRCL Evaluations.
67. Ibid.
68. Ibid.
69. Ibid.
70. Ibid.
71. 2013 ICE Segregation Directive.
72. Of note, some facilities may be bound by the Performance-Based National Detention Standards or other versions of the NDS but the requirements regarding solitary confinement procedures, minimum standards of care, and procedures for implementing and carrying out solitary confinement are generally consistent across them.
73. Appendix A for questionnaire.
74. U.S. Immigration and Customs Enforcement, "Review of the Use of Segregation for ICE Detainees," 2013, https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.
75. HLS FOIA: Spreadsheet.
76. Ibid.
77. Ibid.
78. Ibid. Seven of these solitary confinement placements were initiated in response to immigrants requesting solitary confinement. The longest lengths of solitary confinement placements that were specifically facility-initiated include: 637 days (Northwest ICE Processing Center, WA), 519 days (Adelanto ICE Processing Center, CA), 485 days (Imperial Regional Detention Facility, CA), 444 days (Nye County Detention Center, NV), 414 days (Northwest ICE Processing Center, WA), and 404 days (Central Louisiana ICE Processing Center, LA).
79. CoreCivic, Detention Facilities, https://www.corecivic.com/facilities, last visited January 10, 2024 (listing Eloy Federal Contract Facility and Otay Mesa Detention Center); The Geo Group, Inc., Our Locations, https://www.geogroup.com/LOCATIONS, last visited January 10, 2024 (listing Denver Contract Detention Facility, Northwest ICE Processing Center); Detainees Leaving ICE Detention from the Buffalo Service Processing Center (Federal Detention Facility), Syracuse TRACImmigration, https://trac.syr.edu/immigration/detention/201509/BTV/exit/, last visited January 10, 2024.
80. HLS FOIA: Spreadsheet.
81. Ibid.
82. Complaint Filed Against ICE As Misuse of Solitary Confinement in Colorado Facility Raises Concerns, July 13, 2023, https://www.americanimmigrationcouncil.org/news/complaint-filed-against-ice-misuse-solitary-confinement-colorado-facility-raises-concerns.
83. HLS FOIA: Spreadsheet.
84. Ibid.
85. Eileen Sullivan, "Crossings at the U.S. Southern Border Are Higher Than Ever," The *New York Times*, October 27, 2023, https://www.nytimes.com/2023/10/21/us/politics/cbp-record-border-crossings.html.
86. HLS FOIA Spreadsheet and ICE Detention Statistics Excel files from 2018-2023 were used to derive the proportion, https://www.ice.gov/detain/detention-management.
87. HLS FOIA: Spreadsheet; Physicians for Human Rights, "Praying for Hand Soap and Masks: Health and Human Rights Violations in U.S. Immigration Detention During the COVID-19 Pandemic," January 2021, 10.
88. HLS FOIA: Spreadsheet.
89. HLS FOIA 2023: Q3 Segregation Metrics from ICE's Detention Monitoring Council's Quarterly Meeting on September 2023, released on October 16, 2023 [hereinafter HLS FOIA: 2023 Q3 Segregation Metrics].
90. HLS FOIA: 2023 Q3 Segregation Metrics.
91. HLS FOIA: Spreadsheet.
92. Ibid.
93. U.S. Immigration and Customs Enforcement, *Review of the Use of Segregation for ICE Detainees.*
94. HLS FOIA: E-mail from the Department of Homeland Security's Office for Civil Rights and Civil Liberties, sent on April 22, 2016 [hereinafter HLS FOIA: CRCL E-mail].
95. POGO FOIA: Spreadsheet Showing Solitary Confinement Stays Between January 2016 and May 2018 [hereinafter POGO FOIA: Spreadsheet].

Endnotes

continued

96. "Complaint Detailing Abusive Overuse of Solitary Confinement and Mistreatment that Disproportionately Impacts Persons with Disabilities at the Aurora Contract Detention Facility," American Immigration Council, National Immigration Project, and Rocky Mountain Immigrant Advocacy Network, July 13, 2023, https://www.americanimmigrationcouncil.org/sites/default/files/research/misuse_of_solitary_confinement_in_colorado_immigration_detention_center_complaint.pdf. [hereinafter American Immigration Council Complaint].
97. American Immigration Council Complaint.
98. HLS FOIA: Evaluations Conducted by the Department of Homeland Security's Office for Civil Rights and Civil Liberties on ICE Detention Facilities Between 2012 and 2014, released on October 25, 2023 [hereinafter HLS FOIA: CRCL Evaluations].
99. HLS FOIA: CRCL Evaluations.
100. Ibid.
101. Ibid.
102. HLS FOIA: 2023 Q3 Segregation Metrics.
103. POGO FOIA: Spreadsheet.
104. Ibid.
105. Dana Salvano-Dunn, "Retention Memo: Segregation of Individuals with a Mental Health Disability and/or Serious Mental Illness," U.S. Department of Homeland Security, September 1, 2023, https://www.dhs.gov/sites/default/files/2023-09/23_0901_crcl_retention_memo_to_ice_segregation_mental_health_or_illness_redacted_508.pdf.
106. American Immigration Council Complaint, at 15.
107. Dana Salvano-Dunn, "Retention Memo."
108. United Nations, "Special Rapporteur on Torture Tells Third Committee Us of Prolonged Solitary Confinement on Rise, Calls for Global Ban on Practice," October 18, 2011, https://press.un.org/en/2011/gashc4014.doc.htm#:~:text=The%20Human%20Rights%20Council's%20Special,terror%E2%80%9D%20and%20%E2%80%9Cthreats%20to%20national.
109. U.S. Immigration and Customs Enforcement, Review of the Use of Segregation for ICE Detainees, 2013.
110. HLS FOIA: Spreadsheet.
111. Ibid.
112. Ibid.
113. DHS OIG, "ICE Needs to Improve its Oversight of Segregation Use in Detention Facilities," October 13, 2021, https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf, GAO Report, HLS FOIA: Spreadsheet and ICE Detention Statistics, https://www.ice.gov/detain/detention-management.
114. HLS FOIA: Spreadsheet. This percentage is calculated from the number of people in solitary confinement with recorded mental health status.
115. HLS FOIA: Spreadsheet.
116. Ibid.
117. Ibid.
118. Ibid.
119. U.S. Immigration and Customs Enforcement, ICE Directive 11063.2, "Identification, Communication, Recordkeeping, and Safe Release Planning for Detained Individuals with Serious Mental Disorders or Conditions and/or Who are Determined to Be Incompetent by an Immigration Judge," April 5, 2022, https://www.ice.gov/doclib/news/releases/2022/11063-2.pdf.
120. Memo from DHS Office of Civil Rights and Civil Liberties and the Office of General Counsel to ICE, "Retention Memo: Segregation of Individuals with a Mental Health Disability and/or Serious Mental Illness," September 1, 2023, https://www.dhs.gov/sites/default/files/2023-09/23_0901_crcl_retention_memo_to_ice_segregation_mental_health_or_illness_redacted_508.pdf.
121. Stuart Grassian, "Psychiatric Effects of Solitary Confinement."
122. POGO FOIA: Spreadsheet.
123. Ibid.
124. Ibid.
125. HLS FOIA: CRCL Evaluations.
126. Ibid.
127. Ibid.
128. Grassian, "Psychiatric Effects of Solitary Confinement."
129. HLS FOIA: CRCL Evaluations.
130. Ibid.
131. Ibid.
132. Ibid.
133. Ibid.
134. Ibid.
135. "National Detention Standards for Non-Dedicated Facilities," ICE, Revised 2019, https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf.
136. Ibid.
137. John Leach, "Psychological factors in exceptional, extreme and torturous environments," *Extreme physiology & medicine 5* (2016): 1–15.
138. Loran F. Nordgren, Mary-Hunter Morris McDonnell, and George Loewenstei, "What constitutes torture? Psychological impediments to an objective evaluation of enhanced interrogation tactics," Psychological science 22, no. 5 (2011): 689-694; Peeler K, Hampton K, Lucero J, Ijadi-Maghsoodi R., "Sleep deprivation of detained children: another reason to end child detention," *Health and human rights journal 21*, no. 1 (2019): 317-320, https://www.hhrjournal.org/2020/01/sleep-deprivation-of-detained-children-another-reason-to-end-child-detention/.
139. "National Detention Standards for Non-Dedicated Facilities."
140. Ibid.
141. Ibid.
142. Ibid.
143. Ibid.
144. Ibid.
145. Ibid.
146. Ibid.
147. Ibid.
148. "National Detention Standards for Non-Dedicated Facilities"; "ICE Health Service Corps," Immigration and Customs Enforcement, accessed October 18, 2023, https://www.ice.gov/features/health-service-corps.
149. "National Detention Standards for Non-Dedicated Facilities."
150. "The HIPAA Privacy Rule," Office for Civil Rights, https://www.hhs.gov/hipaa/for-professionals/privacy/index.html.
151. Dekker AM, Farah J, Parmar P, Uner AB, Schriger DL, "Emergency Medical Responses at US Immigration and Customs Enforcement Detention Centers in California," *JAMA Netw Open* 6, no. 11 (2023):e2345540. doi:10.1001/jamanetworkopen.2023.45540.
152. "ICE Health Service Corps," Immigration and Customs Enforcement, accessed October 18, 2023, https://www.ice.gov/features/health-service-corps.
153. Grassian, "Psychiatric Effects of Solitary Confinement."
154. U.S. CONST, Amend, V.
155. Zadvydas v. Davis, 533 U.S. 678, 693 (2001).
156. DeShaney v. Winnebago Cty. Dep't. of Soc. Servs., 489 U.S. 189, 199-200 (1989).
157. *Youngberg v. Romeo,* 457 U.S 307, 322 (1982).
158. Alina Das, "Immigration Detention and Dissent: The Role of First Amendment on the Road to Abolition," *Georgia Law Review* 56, no. 4 (2022), https://digitalcommons.law.uga.edu/cgi/viewcontent.cgi?article=1215&context=glr.
159. Aleksandr Sverdlik, "Border Patrol and ICE Routinely Violate Immigrants' Religious Rights," ACLU, March 20, 2019, https://www.aclu.org/news/immigrants-rights/border-patrol-and-ice-routinely-violate.
160. 2013 ICE Segregation Directive, https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf; Detention Management, "U.S. Immigration & Customs Enforcement," https://www.ice.gov/detention-management; "Hearing Regarding Oversight of Detention Facilities Before the Subcomm. on Oversight, Management, & Accountability of the H. Comm. on Homeland Security," 116th Cong. 2, 3, 2019 (statement of Tae Johnson Assistant Director for Custody Management, Enforcement and Removal Operations, U.S. Customs and Immigration Enforcement) (hereinafter, ICE Testimony).
161. "2019 National Detention Standards for Non-Dedicated Facilities," https://www.ice.gov/detain/detention-management/2019; "2011 Operations Manual ICE Performance-Based National Detention Standards," https://www.ice.gov/detain/detention-management/2011 ("PBNDS 2011 reflects ICE's ongoing effort to tailor the conditions of immigration detention to its unique purpose while maintaining a safe and secure detention environment for staff and detainees …. PBNDS 2011 is crafted to improve medical and mental health services … [and] improve the process for reporting and responding to complaints.").
162. ICE, "2019 National Detention Standards for Non-Dedicated Facilities," https://www.ice.gov/detain/detention-management/2019.
163. *ICE Testimony.*
164. Article 31(2) of the UN Refugee Convention (permitting states to restrict refugee freedom of movement only when "necessary" and only until their legal status is "regularized" or they are admitted to another country); Andreas Zimmermann et al., "The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol: A Commentary," Oxford Public International Law, January 2011, https://opil.ouplaw.com/display/10.1093/actrade/9780199542512.001.0001/actrade-9780199542512.
165. UN Human Rights Committee (HRC), General comment no. 35, Article 9 (Liberty and security of person), December 16, 2014, CCPR/C/GC/35, para 12, 18.
166. UNHCR ExCom, Conclusion No. 44 (1986).
167. United Nations, "Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," Note by Secretary-General A/63/174, 77. Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Report on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Human Rights; Human Rights Committee, General Comment 20, Article 7, 44th Sess., U.N. Doc. HRI/GEN/1/Rev. 1 para 30 (1994).

168. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) A/RES/70/175, January 8, 2016, https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/443/41/PDF/N1544341.pdf?OpenElement.
169. Juan Mendez, Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 21, 26, U.N. Doc. A/66/268 (August 5, 2011), https://digitallibrary.un.org/record/710177?ln=en.
170. United Nations Press Release, Special Rapporteur on Torture Tells Third Committee Use of Prolonged Solitary Confinement on Rise, Calls for Global Ban on Practice, October 18, 2011, https://press.un.org/en/2011/gashc4014.doc.htm. NIJC & PHR, "Invisible in Isolation" (citing Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, para 62 UN Doc A/66/268, August 5, 2011, [prepared by Juan Mendez]).
171. Art. 10, ICCPR. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, December 10, 1984. 1465 U.N.T.S. 85, 113; S. Treaty Doc. No. 100-20 (1988); 23 I.L.M. 1027 (1984).
172. Office of the High Commissioner, UN Human Rights, Press Release, "United States: Prolonged solitary confinement amounts to psychological torture, says UN expert," February 28, 2020, https://www.ohchr.org/en/press-releases/2020/02/united-states-prolonged-solitary-confinement-amounts-psychological-torture.
173. Ibid.
174. Ibid.
175. Inter-American Commission on Human Rights, "Report on Immigration in the United States: Detention and Due Process," at para 337, 2010, https://www.oas.org/en/iachr/migrants/docs/pdf/migrants2011.pdf.
176. At para 45, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CCPR%2FC%2FUSA%2FCO%2F5&Lang=en.
177. Ibid., para 54.
178. The recommendations in this section draw on several different sources, including: Project on Government Oversight, "ISOLATED: ICE Confines Some Detainees with Mental Illness in Solitary for Months," August 2019, https://www.pogo.org/investigation/2019/08/isolated-ice-confines-some-detainees-with-mental-illness-in-solitary-for-months; Physicians for Human Rights, "Praying for Hand Soap and Masks," January 12, 2021, https://phr.org/our-work/resources/praying-for-hand-soap-and-masks/.
179. Maryam Saleh and Spencer Woodman, "A Homeland Security Whistleblower goes Public about ICE Abuse of Solitary Confinement," The Intercept.

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