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Physicians for Human Rights

Using science and medicine to stop human rights violations

Statement for the Record from Physicians for Human Rights

Senate Judiciary Committee, Subcommittee on the Constitution, Civil Rights and Human Rights

"Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences"

June 19, 2012

Dear Chairman Durbin, Ranking Member Graham, and distinguished Members of this Committee:

Physicians for Human Rights (PHR) appreciates this opportunity to join in the growing chorus of calls to end the use of solitary confinement in America's prisons, jails, and detention facilities. As an independent organization that uses medicine and science to stop severe human rights human violations, PHR firmly believes that the well-documented psychological and physiological effects of even a brief period spent in solitary confinement are so detrimental that the practice must be prohibited, except when it is absolutely necessary to protect the lives or safety of others. Mr. Chairman, we applaud your leadership on this important human rights issue and look forward to your continued efforts to curb the use of solitary confinement.

In 1842, Charles Dickens visited the newly-constructed Philadelphia Prison, which kept all of its inmates in solitary confinement for the entire period of their incarceration. After touring this facility, which many held up as a model for prisons across the country, Dickens wrote that an inmate in solitary confinement "is a man buried alive … dead to everything but torturing anxieties and horrible despair."[1]

[1] Charles Dickens, "Philadelphia, and Its Solitary Prison," *American Notes* (1842), *available at* http://www.victorianweb.org/authors/dickens/pva/pva344.html.

Dickens' observation remains true 170 years later. American prisons, jails, and detention facilities use solitary confinement now more than ever, despite overwhelming evidence that it is ineffective, counterproductive, and causes severe mental and physical suffering. While the separation of dangerous or vulnerable inmates from the rest of the prison population is sometimes necessary to running a safe facility, our country's current widespread use of solitary confinement veers far outside the realm of the necessary into the purely punitive.

As the title of this hearing acknowledges, the use of solitary confinement implicates human rights, fiscal, and public safety concerns. But the mere fact that solitary confinement violates fundamental human rights that apply to all individuals – including those in prisons, jails, and detention facilities – is alone enough to warrant an end to the practice in virtually all cases. In the way in which it is used in the United States today, solitary confinement constitutes torture and/or cruel, inhuman, or degrading treatment, in violation of both international law and America's founding principles.

While clearly detrimental to the approximately 25,000 inmates held in isolation in prisons and jails, we note that the use of solitary confinement is particularly inappropriate for detainees in immigration detention facilities and national security detention facilities. Unlike prisons and jails, these detention facilities are used to detain people for administrative purposes – not as punishment for having been convicted of a crime. Many detainees in these facilities have been tortured in the past or suffer from mental illnesses, making them particularly susceptible to the harmful psychological effects of solitary confinement. And oversight and avenues for judicial review in these facilities are sorely lacking, leaving detainees with few options for challenging their placement in solitary. We urge Congress to hold additional hearings to examine the use of solitary confinement in these settings.

Given Physicians for Human Rights' medical and scientific expertise, we will focus our testimony on the psychological and physiological effects of solitary on inmates and detainees. These effects are well-documented, pervasive, and uniformly negative across all populations held in solitary.

Psychological Effects

Almost since solitary confinement was first used in the early 19th century, its harmful psychological effects have been well-documented. In fact, shortly after solitary confinement was established in the United States as a means of incarceration, the high rates of severe mental disturbances resulting from solitary confinement caused it to fall into disuse.[2] Early observers noted that even among prisoners with no prior history of mental illness, those held in solitary confinement exhibited "severe confusional, paranoid, and hallucinatory features," as well as "random, impulsive, often self-directed violence."[3] For those who entered prison with a

[2] Stuart Grassian, "Psychiatric Effects of Solitary Confinement," *Washington University Journal of Law and Poilcy* 22:325-383 (2006), at 328.
[3] Id.

preexisting mental illness – as a disproportionately large portion of today's incarcerated population do – solitary confinement exacerbated those conditions.[4]

Recent research has confirmed that solitary confinement often results in a syndrome described as "prison psychosis," the symptoms of which include anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, psychosis, and self-harm.[5] Dr. Stuart Grassian, a noted expert on the psychological effects of solitary confinement, has identified a group of symptoms associated with solitary confinement:

- Hyperresponsivity to external stimuli;
- Perceptual distortions, illusions, and hallucinations;
- Panic attacks;
- Difficulties with thinking, concentration, and memory;
- Intrusive obsessional thoughts;
- Overt paranoia;
- Problems with impulse control, including random violence and self-harm.[6]

This combination of symptoms – some of which Grassian notes are found in virtually no other psychiatric illnesses – together form a unique psychiatric syndrome resulting exclusively from solitary confinement.[7]

While the mental health effects of even a short, defined period of time in solitary confinement can be disastrous, many individuals are held in solitary for prolonged or indefinite lengths of time. These individuals "are in a sense in a prison within a prison,"[8] and the effects on mental health are correspondingly severe. The effects of prolonged solitary confinement, which the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment defines as solitary confinement lasting longer than 15 days,[9] include symptoms of post-traumatic stress such as flashbacks, chronic hypervigilance, and hopelessness; and continued intolerance of social interaction after release.[10]

Furthermore, the deleterious effects of solitary confinement can be even more pronounced among the high proportion of inmates and detainees in American prisons and detention facilities who suffer from preexisting personality disorders or other mental health

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[4] Id. at 329.
[5] Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, ¶62, U.N. Doc. A/66/268 (August 5, 2011) (*prepared by* Juan Mendez) (*hereinafter* "Mendez Report"), *available at* http://www.ohchr.org/EN/Issues/Torture/SRTorture/Pages/SRTortureIndex.aspx.
[6] Grassian, "Psychiatric Effects of Solitary Confinement," at 335-36.
[7] Id. at 337.
[8] Mendez Report at ¶ 57.
[9] Mendez at ¶ 79.
[10] Grassian, "Psychiatric Effects of Solitary Confinement," at 353.

problems.[11] Indeed, such inmates are the most likely to develop psychoses after being placed in solitary confinement.[12] But even inmates with histories of relatively strong psychological functioning suffer severe psychological trauma as a result of solitary confinement.[13]

Moreover, the negative mental health effects of solitary confinement often continue after an inmate is released, as most eventually are. One notable study found that the symptoms of prison psychosis last long after release from solitary confinement, while lasting personality changes resulting from solitary can permanently impair social interaction.[14] This not only inhibits an inmate's ability to adjust to life in the general prison population – where maladjustment often leads to disciplinary infractions, which in turn lead to more solitary confinement – but severely impairs a released inmate's ability to safely and successfully reintegrate into general society, effectively defeating any purported rehabilitative component of incarceration.[15] Instead of curing antisocial behavior, solitary confinement exacerbates it, perpetuating a cycle that results in more incarceration and more solitary confinement.

In interviews of inmates who were released from prison after spending time in solitary, many report having difficulty interacting with their families. One describes how he "curls up in a corner of his apartment, blinds drawn, alone," while another gave himself a black eye while on parole.[16] Eighteen months after being released back into society from solitary confinement, Brian Nelson describes how he feels every day: "People ask me what hurts. I say the box, the gray box. I can feel those walls and I can taste them every day of my life. I'm still there, really. And I'm not sure when I'm ever gonna get out."[17]

The potential for this cycle is particularly worrisome for immigration and national security detainees, the vast majority of whom are released back into society. Indeed, such detainees are held with the intention of temporary detention and the presumption of future release. Safe reintegration into society is imperiled when these detainees are isolated in solitary confinement.

In short, the lack of social interaction that is the defining feature of solitary confinement causes severe psychological impairment in inmates and detainees that is severely disproportionate to almost any possible reason for their placement in solitary.

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[11] Id. at 348.
[12] Id. at 349.
[13] Id. at 354.
[14] Sharon Shalev, "A Sourcebook on Solitary Confinement" (2008) (*hereinafter* "Sourcebook") at 13, 22, *available at* http://www.solitaryconfinement.org/sourcebook..
[15] Grassian, "Psychiatric Effects of Solitary Confinement," at 332-33.
[16] Susan Greene, "The Gray Box: An Investigative Look at Solitary Confinement," January 24, 2012, *available at* http://www.dartsocietyreports.org/cms/2012/01/the-gray-box-an-original-investigation/.
[17] Id.

Physiological Effects

Solitary confinement also results in a number of serious and well-documented physiological effects as a result of both the physical manifestations of psychological problems, as well as common features of solitary confinement such as lack of access to fresh air and sunlight, and long periods of inactivity.[18]

Inmates and detainees held in solitary for even a short period of time commonly experience sleep disturbances, headaches, and lethargy. In one study, researchers found that over 80% of the isolated inmates in the study suffered from all three of these ailments, while more than half suffered from dizziness and heart palpitations as well.[19] Inmates in solitary confinement often suffer from appetite loss, weight loss, and severe digestive problems, sometimes resulting from their inability to tolerate the smell or taste of food in an environment of near-total sensory deprivation. Other common signs and symptoms include heart palpitations, diaphoresis, back and joint pain, deterioration of eyesight, shaking, feeling cold, and aggravation of pre-existing medical problems.[20] Moreover, as a result of the psychological trauma common to inmates in solitary confinement, self-harm and suicide are more common in solitary than among the general prison population.[21]

Because inmates in solitary confinement are often kept in separate wings of prisons and detention facilities and are, by definition, separated from other inmates, they are more likely to be subjected to excessive force and other physical abuse by corrections officers and guards.[22] And because they have more limited access to medical services, both pre-existing illnesses and illnesses resulting from time spent in solitary confinement often go untreated.

Conclusion

The physiological and, especially, psychological harm caused by even a relatively short period in solitary confinement is indisputable. A review of the medical literature on solitary confinement by Dr. Craig Haney concludes that "there is not a single published study of solitary or supermax-like confinement in which nonvoluntary confinement lasting for longer than 10 days, where participants were unable to terminate their isolation at will, that failed to result in negative psychological effects."[23] There is no question that the harm caused to an inmate or detainee kept in solitary confinement outweighs any benefit in all but the most extreme cases.

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[18] Shalev, "Sourcebook" at 15.
[19] Id. at 11.
[20] Id. at 15.
[21] Craig Haney and Mona Lynch, "Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement," *New York University Review of Law and Social Change* 23:477-570 (1997), at 525.
[22] Leena Kurki and Norval Morris, "The Purposes, Practices, and Problems of Supermax Prisons," *Crime & Justice* 28:385-424 (2001), at 409.
[23] Craig Haney, "Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement," *Crime & Delinquency* 49:124-156 (2003), at 132.

Social interaction is neither a right nor a privilege – it is a fundamental human need. "Simply to exist as a normal human being," writes Atul Gawande, "requires interaction with other people."[24]

Physicians for Human Rights urges members of Congress to work towards ending the use of solitary confinement in all facilities under federal jurisdiction, including federal prisons, immigration detention facilities, and national security detention facilities, in all but the most extreme cases. PHR believes that solitary confinement should never be used as a means of controlling mentally ill inmates and detainees, and that any use of solitary confinement should conform to the recommendation contained in the Istanbul Statement on the Use and Effects of Solitary Confinement: "As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort."[25]

While PHR firmly believes that solitary confinement should be used only in the rarest cases and only as a last resort, we recognize that it will continue to be used in prisons, jails, and detention facilities in the near future. Given the extremely harmful psychological and physiological effects of even a short period of time in solitary confinement, we emphasize that inmates and detainees held in solitary confinement must have the same or greater access to medical and mental health care as the general incarcerated or detained population. Individuals held in solitary must receive daily assessments from qualified medical and mental health professionals, whose ethical obligations are to their patients, not to the detaining authority.

We thank you for the opportunity to submit testimony for this important hearing, and we at PHR stand ready to engage with all congressional leaders to begin a serious dialogue focused on ending the use of this dangerous and counterproductive practice.

[24] Atul Gawande, "Hellhole," *The New Yorker* (March 30, 2009), *available at* http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande.
[25] The Istanbul Statement on the Use and Effects of Solitary Confinement (December 9, 2007), *available at* http://www.solitaryconfinement.org/istanbul.