Dear Chairman Durbin and Ranking Member Graham,

My name is Sharon Shalev. I am a researcher at the Centre for Criminology at Oxford University, a Fellow of the Mannheim Centre for Criminology at the London School of Economics and Political Science, and an Associate of the International Centre for Prison Studies (ICPS).

I have been researching the use of solitary confinement for almost two decades and have written extensively on the subject. In the course of my work I have conducted research on, and published a book about, the American Supermax prisons. I have asked for a copy of the book, titled: "Supermax: controlling risk through solitary confinement" (Willan, 2009) to be sent to you. I am of the view that supermax prisons are excessive, expensive, and extremely harmful to prisoners' health and well being. I also found little evidence that these prisons succeed in reducing prison violence and I believe that they may in fact contribute to increased violence which can then be directed towards others, or inwardly in the form of self harm and suicide.

The harms of solitary confinement are evidenced in a large body of literature, stretching back to the 19th century. I have reviewed this literature, international law standards and regulations and case law and proposed some safeguards in a resource titled "A sourcebook on solitary confinement" which was published in 2008 and is freely available online at: www.solitaryconfinement.org/sourcebook.

For your convenience I enclose an executive summary of the Sourcebook, which I hope that you will find illuminating and useful. I would be delighted to offer further information and any assistance that you may need and look forward to reading the Sub committee's findings.

Yours sincerely,

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A sourcebook on solitary confinement: Executive Summary

Dr Sharon Shalev Mannheim Centre for Criminology, LSE (2008)

About the Sourcebook

The sourcebook, available in full at www.solitaryconfinement.org, provides a single reference point for those concerned with the practice of solitary confinement, particularly when it is imposed for prolonged periods of time. Its purpose is to a) inform prison operational staff, health professionals, and policy makers of the human rights position regarding solitary confinement, of ethical and professional standards and codes of practice relating to prisoner isolation, and of research findings on the health effects of solitary confinement, and b) propose safeguards and best practice in light of the above. More broadly, it aims to raise awareness of the potential consequences of prolonged solitary confinement.

Solitary confinement – an introduction

For the purpose of the Sourcebook, solitary confinement is defined as a form of confinement where prisoners spend 22 to 24 hours a day alone in their cell in separation from each other. An old and enduring prison practice, first widely and systematically used on both sides of the Atlantic in the 'separate' and 'silent' penitentiaries in the 19th century, recent years have seen an expansion in the large scale use of solitary confinement in the form of 'supermax' and 'special security' prisons, particularly in the USA.

The health effects of solitary confinement

There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders, and that it may also actively cause mental illness. The extent of psychological damage varies and will depend on individual factors (e.g. personal background and pre-existing health problems), environmental factors (e.g. physical conditions and provisions), regime (e.g. time out of cell, degree of human contact), the context of isolation (e.g. punishment, own protection, voluntary/ non voluntary, political/criminal) and its duration.

Notwithstanding variations in individual tolerance and environmental and contextual factors, there is remarkable consistency in research findings on the health effects of solitary confinement throughout the decades. These have mostly demonstrated negative health effects, in particular psychological but also physiological. Attested symptoms include anxiety; depression; anger; cognitive disturbances; perceptual distortions, and; paranoia and psychosis. Studies reporting no negative health effects from solitary confinement are few and far between, and virtually no study reports positive effects. The personal accounts of prisoners held in solitary confinement show a striking similarity and consistency with these research findings.

Each of the three main factors inherent in solitary confinement - social isolation, reduced environmental stimulation and loss of control over almost all aspects of daily life - is potentially distressing. Together they create a potent mix, especially when applied to what studies of psychiatric morbidity indicate is a particularly vulnerable population.

Both the duration of solitary confinement and whether the prisoner has prior knowledge of how long the period in solitary confinement will last are important determinants of the adverse health effects. All studies of prisoners who have been detained involuntarily in solitary confinement in regular prison settings for longer than ten days have demonstrated some negative health effects but for shorter periods the evidence is more equivocal. Other studies have shown that uncertainty as to the length of time in solitary confinement promotes a sense of helplessness and increases hostility and aggression.

While some of the adverse health effects of solitary confinement will subside on its termination, others may persist. Unable to regain the necessary social skills for leading a 'normal' life, some of those held in solitary confinement in prison may continue to live in relative social isolation after their release. In this sense, solitary confinement operates against one of the main purposes of the prison which is to rehabilitate offenders and facilitate their reintegration into society.

The decision to place prisoners and detainees in solitary confinement

Where prisoners and detainees are held in solitary confinement, whether in an especially designed free-standing isolation unit or in a designated segregation wing in a general population prison, this is typically on the grounds of: punishment; protection; prison management; national security; pre-charge and pre-trial investigation, or; lack of other institutional solutions.

As solitary confinement is a harsh measure with potentially harmful consequences for the prisoner involved, the decision to place a prisoner in solitary confinement must always be made by a competent body, transparently and in accordance with due process requirements. Human rights bodies view solitary confinement as an undesirable prison practice which can only be justified in extreme cases, must only be used for the shortest possible time, and which, in certain circumstances, may be in violation of international law.

The isolation of those who have not yet been convicted of any crime is particularly problematic, as it inflicts punitive and potentially harmful conditions on people who are innocent until proven guilty, and serves to coerce them. There is consensus amongst observers, experts and, increasingly, the courts, that the mentally ill and those at risk of self harm should not be held in solitary confinement

Whilst the European Court of Human Rights has shown a willingness to accept that solitary confinement may be justified in exceptional cases, particularly those involving offences against the State, the Court has also found that placement in solitary confinement has breached a prisoner's human rights in other circumstances.

Putting aside any legal considerations, studies suggest that, whilst it may be a convenient tool in the short term, solitary confinement is not effective for managing those defined a 'problem' or 'difficult' prisoners in the long term and may even be counter-productive – potentially fragmenting prisoner solidarity an and creating a legitimacy deficit and leading to increased violence.

Design, physical conditions and regime in solitary confinement units

Since prisoners in solitary confinement spend at least 22 hours a day alone in their cells, physical conditions assume particular importance. The United Nations Standard Minimum

Rules (globally) and the European Prison Rules (in Europe) set out minimum requirements in respect of physical conditions and, along with other international instruments prescribe minimum requirements in respect of the prison regime.

Those standards simply set a minimum baseline, which notwithstanding the constraints of a solitary confinement regime, which prison administrations should strive to improve upon. Decent facilities, in-cell provisions, meaningful human contact and access to purposeful activities are likely to mitigate the harmful effect of solitary confinement. Regimes which increase opportunities for social interaction between prisoners and between prisoners and staff, provide for direct supervision of prisoners by staff, and which communicate a more positive message about the prison and the prisoners themselves, are cited as positively influencing behaviour and wellbeing in research.

The extreme nature of solitary confinement and its potential health effects give rise to special human rights concerns, and its use is subjected to close scrutiny by the courts and monitoring bodies. In particular, the physical conditions in which prisoners are held, the regime provisions they enjoy and the degree of human contact they have whilst isolated are assessed on a case by case basis to determine whether it has violated the prohibition against torture, inhuman or degrading treatment or punishment.

The role of health professionals in segregation units

Health professionals working in prisons and other places of detention face some particular challenges which stem from the inherent tension between the role of the prison as a place of punishment through deprivation of liberty, and their role as protectors and promoters of health. The ethical challenges are especially acute when the question of the involvement of health personnel in disciplinary measures arises, and nowhere is this more contentious than in their role, if any, in segregation units.

Prison health staff will almost inevitably be faced with situations where their 'dual loyalty' to a patient and the prison administration conflicts, but they remain bound by the usual established principles of medical ethics that make clear that their duty to the patient takes precedence over any other obligation. The courts have upheld prisoners' rights to appropriate medical care and the normal principles around the confidentiality of medical information continue to apply.

The question of whether health professionals have any role in certifying a prisoner 'fit' to undergo, or continue to be subject to, disciplinary measures, including solitary confinement, is a particularly contentious one, but given the substantial evidence of it adverse health effects, the argument that, in line with the World Health Organisation's guidance, they should not, is persuasive.

Where the use of solitary confinement is abusive and may amount to torture or other forms of ill-treatment, health staff have a duty to report and denounce such acts to the appropriate authorities and professional bodies.

Recommendations

Procedural safeguards

- Inform prisoners, in writing, of the reason for their segregation and its duration.

- Allow prisoners to make representations on their case at a formal hearing.
- Undertake regular reviews of placement – substantive and at short intervals.

These safeguards apply to all forms of solitary confinement.

Placement in solitary confinement

- When used as punishment for prison offences, solitary confinement must only be used as a last resort, and then for the shortest time possible, lasting days rather than weeks or months.
- The use of prolonged solitary confinement for managing prisoners is rarely justified, and then only in the most extreme of cases.
- Those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care.
- The use of solitary confinement for pre-charge and pre-trial detainees must be strictly limited by law and must only be used in exceptional circumstances, with judicial oversight, for as short a time as possible, and never for more than a matter of days.
- Solitary confinement must not be imposed indefinitely, and prisoners should know in advance its duration.
- The use of solitary confinement as a means of coercing or 'softening up' detainees for the purpose of interrogation should be prohibited.

Physical conditions and regime:

- Provide decent accommodation (as per established standards discussed in chapter 4), reflecting the fact that prisoners will spend most of their day in their cell.
- Provide educational, recreational and vocational programmes.
- Provide these activities, wherever possible, in association with others.
- Allow in-cell reading, hobbies and craft materials.
- Ensure that prisoners have regular human contact; encourage informal communication with staff.
- Allow regular and open family visits.
- Enable prisoners a degree of control of their daily lives and physical environment.
- Include a progressive element.

Health

- Health staff must maintain the same standards of care and ethical behaviour as those which apply outside the prison, in particular the right to health care and to privacy and confidentiality.
- Health staff must not participate in the decision to impose or the enforcement of any disciplinary measure.
- Provide mental health training for custodial staff