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Physicians for Human Rights

Using science and medicine to stop human rights violations

March 8, 2013

Mr. Emilio Álvarez Icaza
Executive Secretary
Inter-American Commission on Human Rights
Organization of American States
1889 F Street, NW
Washington, DC 20006

Re: Thematic Hearing on Human Rights and Solitary Confinement in the Americas

Testimony for the Record from Physicians for Human Rights

Esteemed Dr. Álvarez Icaza:

Physicians for Human Rights (PHR), founded in 1986, is an independent, non-profit organization that uses medical and scientific expertise to investigate human rights violations and advocate for justice, accountability, and the health and dignity of all people. We appreciate this opportunity to submit our written testimony to the Inter-American Commission on Human Rights for the **Thematic Hearing on Human Rights and Solitary Confinement in the Americas** to be held on March 12, 2013.

PHR joins in the growing chorus of calls to end the overuse of solitary confinement in prisons, jails, and detention facilities in the United States and elsewhere. As an organization that uses medicine and science to address human rights issues, 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.

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

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inmate in solitary confinement "is a man buried alive ... dead to everything but torturing anxieties and horrible despair."[1]

Dickens' observation remains true 170 years later. US 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, the current widespread use of solitary confinement veers far outside the realm of the necessary into the purely punitive. As to 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 US prisons and jails, we note that the use of solitary confinement is particularly inappropriate for detainees in immigration and national security detention settings. 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, making them particularly susceptible to the harmful psychological effects of solitary confinement. Moreover, oversight and avenues for judicial review in these facilities are sorely lacking, leaving detainees with few options for challenging their placement in solitary. We would urge the Commission to pay particular attention to use of solitary confinement in these settings.[2]

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

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

[2] In April of this year, Physicians for Human Rights will be releasing a detailed report on the use of solitary confinement in US immigration detention facilities and national security detention facilities, such as those at Guantanamo and Bagram, Afghanistan.

[3] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Washington University Journal of Law and Policy 325, 328 (2006).

[4] *Id.* at 329.

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; and
- Problems with impulse control, including random violence and self-harm.[6]

This combination of symptoms – some of which Dr. 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 isolation 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 consequences of prolonged isolation include symptoms of post-traumatic stress such as flashbacks, chronic hypervigilance, and hopelessness, as well as continued intolerance of social interaction after release.[9]

In 1997, a survey of studies resulted in the conclusion that every study of non-voluntary solitary confinement for more than 10 days documented negative psychiatric symptoms in its subjects.[10] More recently, the UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment concluded that solitary confinement essentially becomes "prolonged" at 15 days because some of the harmful psychological effects of solitary confinement may become *irreversible*.[11]

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[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, *supra* note 3, at 335-36.

[7] *Id.* at 337.

[8] *Mendez Report*, *supra* note 5, at ¶57.

[9] Grassian, *supra* note 3, at 353.

[10] Craig Haney and Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. Rev. L. & Soc. Change 477, 525 (1997)).

[11] *Mendez Report*, *supra* note 5, at ¶26.

The harmful effects of solitary confinement can be even more pronounced among inmates and detainees who suffer from preexisting personality disorders or other mental health problems, such as those caused by torture or abuse.[12] Because segregation and solitary confinement is often used as a management tool for mentally ill prisoners and detainees, those with preexisting psychiatric disorders often end up in solitary confinement. When placed in solitary confinement, the mental health problems of these inmates and detainees can be exacerbated and such individuals will tend to experience deterioration in their mental health.[13] But even inmates with histories of relatively strong psychological functioning suffer severe psychological trauma as a result of solitary confinement.[14]

In some settings, isolation is used as an interrogation technique, and may be used alone or in combination with other techniques, aimed at manipulating the senses. The effect of isolation in this context can so negatively impact the psychological and physical well-being of an individual such that it may rise to the level of torture or abusive treatment. In response to disclosures about "enhanced interrogation techniques," the American Psychological Association condemned the use of isolation as an interrogation technique, declaring it absolutely prohibited as it may be considered torture or cruel, inhuman or degrading treatment.[15]

Moreover, the negative mental health effects of solitary confinement often continue after an inmate or detainee 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.[16] This not only inhibits the 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 individual's ability to safely and successfully reintegrate into general society, effectively undermining any purported rehabilitative component of incarceration.[17] 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

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[12] Grassian, *supra* note 3, at 348.

[13] Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 Crime and Justice 441, 474 (2006).

[14] Grassian, *supra* note 3, at 354.

[15] *Reaffirmation of the American Psychological Association Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and its Application to Individuals Defined in the United States Code as "Enemy Combatants,"* American Psychological Association, Resolution adopted by APA on August 19, 2007 and amended by APA on February 22, 2008, available at http://www.apa.org/about/policy/torture.aspx.

[16] Sharon Shalev, *A Sourcebook on Solitary Confinement*, 13, 22 (2008), *available at* http://www.solitaryconfinement.org/sourcebook.

[17] Grassian, *supra* note 3, at 332-33.

of his apartment, blinds drawn, alone."[18] 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."[19]

While the conditions of the detention are similar in many ways to those of criminal inmates, immigration and national security detainees are subjected to a number of additional variables that might exacerbate the psychological harm caused by solitary confinement.

Most significantly, immigration and national security (or "law of war") detainees, who are not in prison for having committed a crime and thus are not serving a sentence, have no idea when, if ever, they will be released. Thus, when in isolation, they do not know how long they will have to endure such conditions. The uncertainly can cause enormous stress on an already psychologically difficult situation. Additionally, many individuals in immigration detention have survived persecution and torture in their countries of origin. Others are survivors of human trafficking, domestic violence, sexual assault, and other crimes—some of which occurred in the United States. They are often alone and terrified, unsure if they will be deported, and they frequently suffer from severe anxiety, depression, and Post-Traumatic Stress Disorder (PTSD). Likewise, many national security detainees were subject to torture and abuse by foreign authorities before being turned over to US custody. Some detainees were subject to torture and abuse by US military or officials while in US custody. Records indicate that some detainees at Guantanamo suffer from PTSD on account of their treatment before and while in US custody.[20] Some of these men are then put into isolation or segregation for disciplinary problems. Without treatment, immigration and national security detainees alike will experience deteriorating psychological states during their weeks, months, or years in detention.

In one groundbreaking study of detained asylum seekers, the majority of whom have survived torture and persecution before fleeing to the US and requesting asylum, investigators found extremely high rates of anxiety, depression, and PTSD symptoms among detainees.[21] The use of segregation and solitary confinement in immigration detention was potentially re-traumatizing for these asylum seekers, particularly for those who were forcibly isolated as part of the

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[18] Susan Greene, *The Gray Box: An Investigative Look at Solitary Confinement* (Jan. 24, 2012), *available at* http://www.dartsocietyreports.org/cms/2012/01/the-gray-box-an-original-investigation/.

[19] *Id.*

[20] *See* Drs. Vincent Iacopino and Stephen N. Xenakis, Brig. Gen. (ret.), *Neglect of Medical Evidence of Torture in Guantanamo Bay: A Case Series*, 3, PLoS Med 8(4) (2011), *available at* http://www.plos.org/media/press/2011/plme-08-04-Iacopino.pdf?s_src=CAT%2520press%2520release&s_subsrc=PLoS.

[21] Physicians for Human Rights and The Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers*, 56-57 (2003) (hereinafter *From Persecution to Prison*). Among the surveyed population, researchers found clinically significant symptoms of anxiety in 77%; depression in 86%; and PTSD in 50%; Forty-four percent had symptoms of all three disorders. *Id.* at 57. A similar study of formerly-detained asylum seekers in Australia likewise found that prolonged detention contributed to a risk of ongoing depression, PTSD, and other mental health issues even after the period of detention had ended. *See* Zachary Steel *et al.*, *Impact of Immigration Detention and Temporary Protection on the Mental Health of Refugees*, 188 British J. of Psychiatry 58, 62 (2006).

persecution they experienced in their countries of origin.[22] Respondents in this study frequently indicated that the arbitrary nature of the decision to impose segregation compounded the anxiety that detained asylum seekers already felt as a result of being detained.[23]

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

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.[24]

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.[25] 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.[26] In fact, EEG studies of prisoners in solitary confinement demonstrate that their brain waves slowed after a week or more of isolation.[27] 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.[28]

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.[29] 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.

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[22] *From Persecution to Prison*, *supra* note 21, at 115. Among study subjects, 40% had experienced forced isolation in their home countries.

[23] *Id.* at 116.

[24] Shalev, *supra* note 16, at 15.

[25] *Id.* at 11.

[26] *Id.* at 15.

[27] Dr. Atul Gawande, *HellHole*, The New Yorker, (March 30, 2009). EEG-like studies of prisoners in detention camps in the former Yugoslavia during the 1990s showed that the highest amount of brain abnormalities existed in prisoners who had undergone head trauma or solitary confinement. *Id.*

[28] Haney and Lynch, *supra* note 10, at 525.

[29] Leena Kurki and Norval Morris, *The Purposes, Practices, and Problems of Supermax Prisons*, 28 Crime & Justice 28:385-424, 409 (2001).

Conclusion & Recommendations

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."[30] 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. Social interaction is neither a right nor a privilege – it is a fundamental human need. "Simply to exist as a normal human being," writes Dr. Atul Gawande, "requires interaction with other people."[31]

Physicians for Human Rights believes 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."[32] Additionally, solitary confinement should never be used as a means of controlling mentally ill inmates and detainees.

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.

In light of the above conclusions and the recognition that solitary confinement may rise to the level of torture or cruel, inhuman and degrading treatment, Physicians for Human Rights makes the following recommendations[33]:

- A prisoner or detainee should never be kept in solitary confinement for longer than 15 days at a time;
- If solitary confinement is to be used, it must be only in exceptional circumstances; its duration must be as short as possible, and for a definite term that is communicated to the detainee;
- Solitary confinement should only be imposed as a last resort, where less restrictive measures could not be employed for disciplinary purposes;

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[30] Craig Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*, Crime & Delinquency 49:124-156, 132 (2003).

[31] Gawande, *supra* note 27.

[32] The Istanbul Statement on the Use and Effects of Solitary Confinement (Dec. 9, 2007), *available at* http://www.solitaryconfinement.org/istanbul.

[33] These recommendations also draw upon those made in the *Mendez Report*, *supra* note 5.

- While it may be necessary to segregate detainees with mental disabilities from the general population, solitary confinement should never be used on the mentally ill; and
- Qualified medical and mental health personnel who are independent from and accountable to an outside authority must regularly review the medical and mental health condition of detainees in solitary confinement, both at the initiation of solitary confinement and on a daily basis thereafter.

We thank you for the opportunity to submit testimony for this important hearing, and we at Physicians for Human Rights stand ready to assist the Commission regarding this inhuman and counterproductive practice, which is violating the human rights of scores of individuals.

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cc: Andres Pizarro