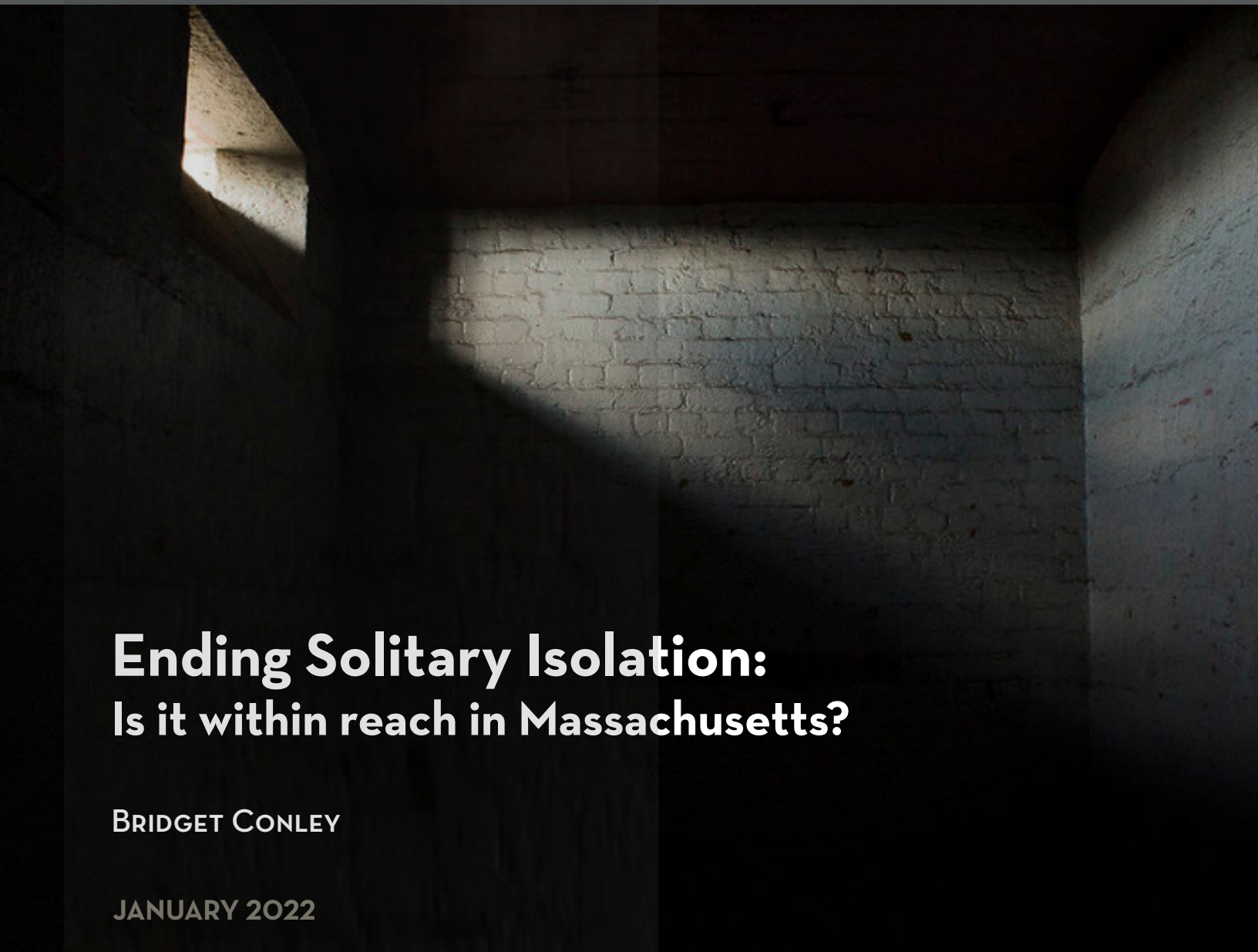


**WORLD PEACE
FOUNDATION**

OCCASIONAL PAPER # 37



Ending Solitary Isolation: Is it within reach in Massachusetts?

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JANUARY 2022



**THE FLETCHER
SCHOOL**

TUFTS UNIVERSITY

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ABOUT

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EXECUTIVE SUMMARY

This paper provides an overview of solitary confinement in Massachusetts' prisons and jails, with focus on the prison system administered by the Commonwealth's Department of Correction (DOC).

The Massachusetts legislature passed major criminal justice reform legislation in 2018, which partially addressed solitary isolation. The new protections included in the legislation were limited to incarcerated people in "restrictive housing," defined as housing where people are locked in cell for 22 or more hours a day. Developments since 2018 raise warning flags that further legislation is required. These include:

1. The DOC and Houses of Correction implemented new forms of solitary which fell just under the regulations imposed by the 2018 CJRA, by keeping people locked in cell 21.5 hours a day. In so doing, they violated the spirit of the law.
2. The U.S. Department of Justice (DOJ) published a report documenting violations of the Constitutional rights of incarcerated people with mental health illness. The DOJ asserted that mental health watch as implemented in Massachusetts must be understood as restrictive housing – even though it was excluded from this category of housing in the 2018 CJRA.
3. The DOC placed the entire population held on the northside of Souza Baranowski Correctional Center (SBCC) in indefinite solitary isolation, locking them in cell 21.5 hours a day, with severe restrictions, including: deprivations of personal belongings, curtailed visitation rights, access to programming, the law library, work opportunities, exercise space, absent the right to a status review process, among other punitive measures.
4. Lockdowns implemented as a response to COVID-19 pandemic imposed solitary-like conditions for large portions of the entire incarcerated population in the state.

These four issues demonstrate that the DOC has used the administrative latitude granted to the agency in the 2018 CJRA to impose the harshest conditions possible without directly circumventing the 2018 CJRA. This is in defiance of the spirit of the law, which was to minimize use of solitary.

Further, the paper argues that the well-documented harms imposed on people subjected to solitary isolation amount to torture. These harmful impacts occur just as much at 21.5 hours as 22 hours locked in cell. Massachusetts' current definition of restrictive housing allows conditions of incarceration that harm people in four primary ways, each of which is documented in the report with illustrations from Massachusetts and in comparative context, drawing on scholarly research. These harms include:

1. Increases in mental health illness;
2. Detriments to physical health;
3. Creation of conditions in which an excessively punitive culture thrives;
4. Detrimental impacts on a wider community of family and friends of an incarcerated person by severely inhibiting meaningful contact with their incarcerated loved one.

The paper also addresses why legislative response is required. It presents international standards, which Massachusetts is not in line with. It further address how, across the United States and in Massachusetts, judicial review has played only a very limited role in reforming prison practices. Drawing on examples of recent changes in other states' policy related to solitary isolation, significant change is possible. But the record also shows that change only comes about when legislators take strong action. Where reforms have occurred, prison administrations have repeatedly pushed back and tried to undermine the reforms by introducing new mechanism for isolating incarcerated people. Until legislation explicitly mandates it, major reforms that aim to minimize the use of solitary will not have the desired impact.

SOLITARY BY ANY OTHER NAME:

A note on language

An experiment with solitary isolation began in the U.S. in the early 1800s, under a theory of rehabilitation through isolation and prayer (the penitentiary). By the 1860s, the results were widely seen as disastrous: severe mental illness resulted.¹ While various forms of solitary existed in the subsequent years, it was not until the 1980s, with the introduction of supermax prisons, that solitary returned in large scale to American prisons. The supermax began as a lockdown in response to violence, turned into indefinite conditions of locking an entire prison population in cell for just under 24 hours/day. Prisons and jails across the range of security levels soon followed suit, instituting practices of isolation for disciplinary reasons, before or after transport between facilities, to “protect” an incarcerated person from threats in the general prison population, to protect a facility from someone deemed especially dangerous (often because of a perceived gang affiliation), or as punishment for acts committed while in prison or jail (as serious as murder or assault, but also minor infractions, like “talking back” to an officer).

The return to solitary in the 1980s was not based on new research that it would improve behavior or conditions. It was a “correctional expedient,”² as prison administrators responded to overcrowding, widespread social and political abandonment of rehabilitation in favor of viewing criminal justice as having a sole purpose of punishment, and the loss of positive incentives through which to influence behavior. Over subsequent decades, many prisons in the U.S. began to expand their capacity to impose solitary isolation on growing numbers of incarcerated people by building more housing units for this purpose.³ It has also been used extensively during the “war on terror.”⁴

During this period of expanded use, the term “solitary isolation” has given way to a range of other names, with restrictive housing often used as a catchall. The term “solitary isolation” is associated with harmful impacts on incarcerated people. In an effort to differentiate new practices from the association with harm and with a nod to “reform” (as little as one hour a day “out of cell”), prison administrators began introducing terms to describe various housing conditions that separate (“segregate”) a person from the general population. As reported in a 2015 study by the Bureau of Justice Statistics (BJS), assessing nationwide trends became complicated given the multiplication of naming practices and variations on time out of cell, purpose for isolation, and du-

1 Smith, Peter Scharf, 2006. “The Effects Solitary Isolation on Prison inmates: A Brief History and Review of the Literature,” *Crime and Justice* 34:1, 441 – 528.

2 Haney, Sean, 2018. “Restricting the Use of Solitary Confinement,” *Annual Review of Criminology* 1, 285 – 310, p, 288

3 Smith 2006; and Sakoda, Ryan T., and Jessica T. Simes, 2021. “Solitary Confinement and the U.S. Prison Boom,” *Criminal Justice Policy Review*, 32:1, 66 – 102.

4 Forman, James, 2009. “Exporting Harshness: How the War on Crime Helped Make the War on Terror Possible,” *New York University Review of Law and Social Change* 33: 3, 331 – 374.

ration of placement.⁵ The BJS opted to use the term “restrictive housing” as a general term. It was defined as: “disciplinary segregation, administrative segregation (largely nonpunitive in nature), or solitary confinement (involving isolation and relatively little out-of-cell time), restrictive housing typically involves limited interaction with other inmates, limited programming opportunities, and reduced privileges.” Today, nationwide, the term “restrictive housing” commonly means keeping someone locked in cell for 22 or more hours a day.

Equally important are the vernacular names for solitary that are based on how it is experienced by incarcerated people. In Massachusetts, this includes: “the box” or the “hole.”

Throughout this paper, I use the term “solitary isolation” as the larger category to capture multiple forms of isolation currently in use in Massachusetts. While it is common practice to use quantitative definitions that hinge on hours in cell per day, a far more significant factor is the deprivation of “normal, direct and meaningful social contact and access to positive environmental stimulation.”⁶ It is this component of isolation that is key to its detrimental impacts. I use a definition proposed by proposed by scholars Ashley Rubin and Keramet Reitera, who argue that solitary should be defined by practices at “the intersection of two of the most restrictive conditions of incarceration—reducing prisoners’ freedom of movement by maximizing ‘time in cell’ and constraining human contact (both physical and social) so severely as not to be ‘meaningful.’”⁷

These two key elements, extreme restrictions on movement and meaningful human contact, define solitary isolation herein.

5 Beck, Allen J., 2015. “Use of Restrictive Housing in U.S. Prisons and Jails, 2011 – 12,” U.S. Department of Justice, Bureau of Justice Statistics, October. Available at <https://bjs.ojp.gov/content/pub/pdf/urhuspj1112.pdf> (Accessed 21 November 2021), p. 2.

6 Haney 2018, p. 286.

7 Rubin, Ashley T. and Keramet Reiter, 2018. “Continuity in the Face of Penal Innovation: Revisiting the History of American Solitary Confinement,” *Law & Social Inquiry* 43:4, 1604 – 1632, p. 1608.

I. Introduction

In 2018, Massachusetts passed the Criminal Justice Reform Act (CJRA), which was hailed as a “blueprint” for criminal justice reform in the United States.⁸ Among the issues it addressed was solitary confinement, termed “restrictive housing.” The legislation aimed to reduce the use of solitary given its well-documented psychological and physical harms, by increasing the articulated rights of incarcerated people held in restrictive housing, creating an oversight committee, and imposing new reporting requirements.

Nonetheless, not long after the CJRA passed, it became clear that the reform of solitary isolation had not gone far enough. There were longstanding issues left unaddressed in the CJRA, and new developments, including:

1. Massachusetts Department of Correction’s (MADOC) creation of categories of solitary that fell just under the limits imposed by the CRJA and hence evaded the protections created by the legislation;
2. The transformation of the entire north side of Souza Baranowski Correction Center (SBCC) into solitary incarceration;
3. New revelations from the Department of Justice (DOJ) about the abuse of the Constitutional rights of people on “mental health watch”; and
4. Extended “lockdowns” during the COVID-19 pandemic.

In 2021, a coalition of civil society groups, many of them affiliated with the Massachusetts Coalition Against Solitary (MASC), and state lawmakers championed new legislation -- **S.1578/H.2504, Criminal Justice Protections to all Prisoners in Segregated Confinement** -- that would close loopholes and bring the state closer to ending solitary isolation in all its forms. This written submission is intended to provide research background on the uses of solitary today.

This paper is divided into four sections. Part I provides an overview of the forms of solitary that exist today in Massachusetts’ prisons. Part II addresses four kinds of harms that are imposed through solitary isolation: psychological, physical, creation of a culture of harm, and detrimental communal impacts. Part III discusses Massachusetts in comparison with international standards and other states in the US that have sought to make reforms – including the crucial role that legislators have played. Part IV concludes.

Throughout, this paper draws on a definition of solitary proposed by scholars Ashley Rubin and Keramet Reitera. They argue that solitary should not be defined primarily in relation to specific hours per day in cell or other quantitative measurements, but by practices at “the intersection of two of the most restrictive conditions of incarceration—reducing prisoners’ freedom of movement by maximizing ‘time in cell’ and constraining human contact (both physical and social) so severely as not to be ‘meaningful.’”⁹ These two key elements, extreme restrictions on movement and meaningful human contact, define solitary isolation in this paper.

8 Clark, Dartunorro, “Massachusetts has a blueprint for what’s next in criminal justice reform,” NBC News, 24 December 2019. Available at <https://www.nbcnews.com/politics/politics-news/massachusetts-has-blueprint-what-s-next-criminal-justice-reform-n1105911>, visited 9 November 2021.

9 Rubin, Ashley T. and Keramet Reiter, 2018. “Continuity in the Face of Penal Innovation: Revisiting the History of American Solitary Confinement,” *Law & Social Inquiry* 43:4, 1604 – 1632, p. 1608.

II. How does solitary isolation continue in Massachusetts following the CJRA of 2018?

According to Senator William Brownsberger, who led the legislative process that culminated in the 2018 CJRA, the reform effort aimed to address a “dilemma” in how Massachusetts uses solitary isolation.¹⁰ The dilemma concerned how to balance the well-documented harms experienced by people who are placed in solitary isolation and the simultaneous need for serious punishment when an incarcerated person commits a serious crime behind while incarcerated. The sole example that the legislator offered to illustrate the need for solitary, was homicide. As the Senator’s website states: “In fact, some believe that [any solitary confinement over 15 days is unacceptably harmful](#). Yet, if a prisoner kills another prisoner, a punishment limited to 15 days, as some have proposed, would seem to trivialize the taking of a life.”¹¹

The spirit of the CJRA was expressed in measures designed to balance these opposing needs.¹² To this end, it issued guidance to the MADOC Commissioner to “maximize out-of-cell activities in restrictive housing and outplacements from restrictive housing consistent with the safety of all persons.”¹³ It also instituted new safeguards: an oversight committee, procedural protections regarding placement into and exit from restrictive housing, guaranteed access to programming after a certain point in time, reporting requirements and guidelines so that people would not release back into society directly from solitary isolation. The CJRA explicitly forbade placing people with mental health illness, pregnant women, juveniles, and people with permanent physical disabilities into solitary. It further made explicit that incarcerated people who identify as LGBTQI cannot, on basis of that identity alone, be placed into administrative segregation (for that person’s “protection”). In short, the law expressed a desire to decrease the use of solitary, while maintaining it as an exceptional disciplinary measure and to counter serious threats to safety.

Nonetheless, in practice, the CJRA ceded considerable discretion to the MADOC and sheriffs. Thus, while homicide perpetrated inside a prison was the signature public illustration of an act that would justify solitary, the CJRA allowed broad criteria for who might be placed into solitary:

1. Someone accused of or found guilty of a disciplinary action.¹⁴ Discipline inside the prisons or HOCs is an administrative process, not a legal one, despite the severity of punishment – up to ten

10 Brownsberger, Will, “Solitary Confinement in the Criminal Justice Package,” Will Brownsberger – State Senator (website), 13 June 2018. Available at: <https://willbrownsberger.com/solitary-confinement-in-the-criminal-justice-package/> (visited 9 November 2021).

11 *Ibid.*

12 See Quandt, Katie Rose, 2019. “Massachusetts Department of Correction Gives a Lesson in How to Get Around Solitary Confinement Reforms,” *Confinement Watch*, November 20. available at: <https://solitarywatch.org/2019/11/20/massachusetts-department-of-correction-gives-a-lesson-in-how-to-get-around-solitary-confinement-reforms/>

13 Brownsberger.

14 See Becker, Deborah, 2021. “30 new COVID cases reported in Massachusetts prisons,” *WBUR*, 10 August, available at: <https://www.wbur.org/news/2021/08/10/souza-baranowski-prisoners-coronavirus-positive-cases> [visited 1 November 2021]. While there is a 90-day review for people in the DDU, it is done by the DOC, the same administrators who put the person there in the first place. See, ‘Not even a lawyer can get you out of solitary confinement,’ *Slate Magazine*, June 3, 2020. Available at: <https://slate.com/news-and-politics/2020/06/solitary-confinement-prison-reform-massachusetts.html> (visited 1 November 2021).

years in solitary for each infraction – that can result. Disciplinary infractions can include very serious crimes, like homicide, but that is exceptionally rare. Infractions can also include assaults against staff or other incarcerated people or getting in a fight, but also not wearing a mask during the COVID pandemic, speaking to the media, or filing a grievance form.

2. Someone who, if placed in the general population would pose an unacceptable risk:
 - a. to the safety of others;
 - b. of destruction or property; or
 - c. to the operation of a correctional facility.

Further, the CJRA restrictions and new forms of oversight applied only to people in two conditions. First, those held in the Departmental Disciplinary Unit (DDU), where a person could be sentenced for up to ten years per infraction.¹⁵ The second condition was people with *restrictive housing status* – defined as those held alone in their housing unit for 22 or more hours per day.

It is important to emphasize that restrictive housing is a *status* not a particular set of housing units. An incarcerated person with a restrictive housing status can be housed in Restrictive Housing Units (RHU), but they might also be housed in, for instance, a Health Services Unit (HSU) or even transferred between prisons and housing units. *Restrictive housing status* adheres to the person, not a location. By the same token, someone might *not* be considered to have the status of restrictive housing yet be housed in an RHU or one of a multitude of similar such units (which are often given different names at each prison or HOC).

The CJRA specifically proclaimed that three groups would not be considered as having restrictive housing status:

1. People who are being observed for mental health evaluation;¹⁶
2. The entirety of the incarcerated population at SBCC; and
3. People held in cell for less than 22 hours per day.

These limits to the CJRA became glaringly problematic over the subsequent years, as the DOC began to implement the 2018 legislation. Four key issues arose: new forms of solitary isolation that fell just under the limit of 22 hours a day in cell, the transformation of the entire Northside of SBCC into a wing for solitary isolation; a 2020 DOJ report citing violations of constitutional rights of people in mental health watch and refuting the propositions that mental health watch does not constitute “restrictive housing”; and the extended lockdowns implemented as response to COVID-19. Each is further explained below.

A. DOC’s creation of new forms of solitary isolation

The DOC responded to the CJRA by creating a range of housing units or statuses where people are held in their cells for 21.5 hours a day – just 30 minutes under the limit where reporting and safeguards were

15 Falcon, 2021. “Elevating the Systems: Exploring Alternatives to Restrictive Housing,” submitted March 2021, available at <https://www.mass.gov/doc/falcon-report/download> (visited 2 November 2021), p. 9.

16 The 2018 CJRA expanded the definition of a Serious Mental Illness (SMI). According to the Falcon report, the number of incarcerated people with an SMI quadrupled overnight as a result of the definition found in the CJRA (Falcon, p. 13).

instituted. There is no publicly available list of all such housing units or statuses, but I was able to identify 7 different statuses and/or housing units where people are held for 21.5 hours a day in the DOC alone (setting aside the Houses of Correction). Among these are:

- **Accountability Program Unit (APU)** at MCI-Framingham (women’s prison). The DOC describes it as “a leveled unit that is designed to address an inmate’s underlying reasons for engaging in disruptive behavior in the facility.”¹⁷
- **Containment Unit (CU)**, formerly Intensive Treatment Unit (ITU), at Old Colony Correctional Center (OCCC).¹⁸
- **Limited Privileges Unit (LPU)** “is a specialized unit for inmates who have demonstrated the need for a more structured environment. Inmates in the LPU may be awaiting adjudication on a serious disciplinary matter, may be serving a disciplinary sanction (not more than 15 days), and/or are stepping down from the DDU or a Restrictive Housing Unit in preparation for release to General Population or to the community. [...] The LPU allows for the opportunity for inmates to re-socialize with small groups of individuals (not more than 5 inmates) during structured and unstructured activities in security chairs. Structured programming is provided 1.5 hours per day 5 days per week.”¹⁹
- **Secure Adjustment Units (SAU)** are “highly structured units that provide access to cognitive behavioral treatment, education, structured recreation, leisure time activities and mental health services for those inmates diverted from or released from a restrictive housing unit.”²⁰
- **Secure Treatment Units (STU)** are “a maximum security residential treatment program that is not Restrictive Housing and that is designed to provide an alternative to Restrictive Housing for inmates diagnosed with serious mental illness in accordance with clinical standards adopted by the Department of Correction.”²¹ There are two such units in use:²² the **Behavior Management Unit (BMU)**, a 10-bed unit at MCI-Cedar Junction that opened in July 2020²³, and the **Secure Treatment Program (STP)**, a 19-bed unit at SBCC.²⁴

17 EOPS and DOC, 2020. “Request for Response: Agency Document Number: 20-DOC-1000-M03 Prison Recidivism Reduction Programs,” Issued February 21, available online at: <https://www.bidnet.com/bneattachments/?617037786.docx> (visited 1 November 2021), p. 17. Hereafter, “EOPS and DOC RFR”. This RFR was issued by the MADOC to solicit bids “for a comprehensive and integrated network of evidence based, trauma informed, residential and non-residential substance use treatment services and other non-residential programs for male and female inmates” (1). It was the only place I could find a MADOC definition of the APU. Previously, MCI-Framingham had a Closed Custody Unit, which, according to MADOC monthly restrictive housing counts, was closed on July 29, 2020, and changed to North Unit. It is no longer used for restrictive housing, by the DOC definition (see, for example, “Restrictive Housing Report: October 2021” available online at <https://www.mass.gov/doc/restrictive-housing-report-october-2021/download> (visited 1 November 2021), p.1.

18 Disability Law Center (DLC), 2021. “A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served,” July, available at <https://www.dlc-ma.org/wp-content/uploads/2021/07/BSH-Report-7.27.2021.pdf> (visited 1 November 2021), p. 7.

19 EOPS and DOC RFR, p. 15. The RFR was the only MADOC document I could find that described this unit.

20 EOPS and DOC RFR, p. 14 – 15. The MADOC noted that in CY 2019, there were 284 people housed in this unit.

21 103 Mass. Reg. 425.05.

22 EOPS and DOC RFR, p. 14. The MADOC stated that in CY 2019, there were 20 enrollments.

23 Opening date comes from the Falcon report, p. 24.

24 The bed number comes from the Falcon Report, p. 24.

Because there is no state-mandated reporting on these units, there is no public information to help us understand how many people are held 21.5 hours day, potentially for an indefinite duration. From the information I managed to piece together, however, the number is in the hundreds.²⁵

B. An entirely new wing for solitary isolation

In addition to the above categories created to maintain people in solitary without the protections of the 2018 CJRA, the DOC transformed SBCC's Northside: where the entire population is currently held in solitary isolation. Following an attack on three correctional officers, all of whom were injured, on January 10, 2020, the entire prison was re-organized. The process was replete with human rights abuses against incarcerated people.²⁶ As a result of the re-organization, the population of the North side of the prison are subjected to conditions that fall just under the limit of the CJRA. As Prisoner Legal Services reports, people on Northside are "locked in their cells 21.5 hours daily... They have limited property, little to no programming or work opportunities, no access to group worship, and no ability to eat communally."²⁷

C. 'Mental Health Watch' violates peoples' Constitutional rights

A third concern is limits of the CJRA's protections for people on "mental health watch." This issue was dramatically highlighted on 17 November 2020, when the U.S. Department of Justice (DOJ) released a report on its investigation of the Massachusetts Department of Correction.²⁸ As noted, above, the CJRA excluded mental health watch from being categorized as "restrictive housing." Nonetheless, as the DOJ clearly states: "the legislature's decision to exclude mental health units from the definition of 'restrictive housing' does not make it so."²⁹ The report continued:

...the restrictive conditions – including stark physical conditions, the isolating and unnecessarily harsh approach to mental health watch, and the prolonged length of time prisoners spend on mental health watch – subject prisoners to a substantial risk of serious harm.³⁰

25 The EOPS and DOC RFR indicates numbers for some of these units for contract year (CY) 2019: 69 in DDU, 20 in STUs, and 284 in SAUs (see pps. 13, 14, and 15). Further, DLC (2021) writes that a typical day includes 10 men on ISOU and another 30 in RU (p.16). This rough information suggests a minimum of 400 people on any given day, and does not include the LPU or APU, nor does it account for how many different people might be cycled in and out of these units over the course of a year.

26 See: Gavin, Christopher, 2020. "Inmates sue over alleged abuse at Shirley prison," *Boston.com*, February 4. available at: <https://www.boston.com/news/local-news/2020/02/04/inmates-lawsuit-shirley-prison/> (visited 22 November 2021); Conley, Bridget, 2020. "Human Rights Abuses in an MA prison: Interview with Patty DeJuneas," *Reinventing Peace*, October 13, available at: <https://sites.tufts.edu/reinventingpeace/2020/10/13/human-rights-abuses-in-an-ma-prison-interview-with-patty-dejuneas/> (visited 2 November 2021); Arsenault, Mark, Matt Rocheleau, and Patricia Wen, 2021. "The Taking of Cell 15," *Boston Globe*, 14 August 2021. Available at: <https://apps.bostonglobe.com/metro/investigations/spotlight/2021/08/department-of-corrections-investigation/> (visited 2 November 2021).

27 Prisoners' Legal Services, 2021. "Prison brutality at Souza-Baranowski Correctional Center, statement of Prisoners' Legal Services," August 18, available at: <https://plsma.org/prison-brutality-at-souza-baranowski-correctional-center/> (visited 26 October 2021).

28 DOJ, Civil Rights Division, 2020. "Investigation of the Massachusetts Department of Correction," November 17, 2020. Available online at: <https://www.justice.gov/opa/press-release/file/1338071/download> (visited 2 November 2021).

29 DOJ 2020, footnote 9, p. 16.

30 DOJ 2020, p. 15.

DOJ also cited the MADOC’s failure to provide adequate mental health care, and the fact that the MADOC officials “know of the serious harms and are disregarding them.”³¹ (The degree of harm to people on mental health watch will be addressed further, in Section III). The report concluded that the MADOC violated the constitutional rights of incarcerated people who were suffering a mental health crisis.

The MADOC responded to the DOJ report by hiring an outside consulting firm, Falcon, to further investigate conditions within various forms of restrictive housing and make recommendations. Falcon submitted a report, “Elevating the System: Exploring Alternatives to Restrictive Housing,” to the MADOC in March 2021, and it was made public on June 29, 2021.³² The Report stated that mental health watch, some instance of people held in RHUs (longer than 30 days), DDU, LPU, and some other housing for the population with serious mental illnesses constitute “restrictive housing.”³³ They argued that the designation was not just related to time out of cell, rather the critical factor was the “punitive culture” of these housing units.³⁴ Among their recommendations was that the MADOC dissolve the DDU and eliminate all restrictive housing “as currently defined.”³⁵

D. Lockdowns: Insufficient controls separating medical segregation from punitive isolation

A fourth issue that arose after the passage of CJRA was the COVID-19 pandemic. The response of the Sheriffs and MADOC to the COVID-19 pandemic, in keeping with the *ad hoc* development of practices in other prisons and jails across the country, consisted of long-duration lockdowns and medical isolation. Medical isolation was often administered in a manner that was indistinguishable from punitive isolation. While clearly a separate issue from institutionalized practices of solitary isolation, the lockdowns imposed solitary-like conditions for the entire incarcerated population in the state, including imposing severe restrictions on time out of housing units, access to programming, and access to meaningful contact with visitors. While the pandemic caught all of society off guard, it is now well past time to unify the response policies and ensure that there are safeguards to govern all conditions of housing, including medical isolation.

In Massachusetts’ prisons, there have been two phases of lockdown. The first lasted from March 13, 2020, when the DOC suspended family and friend visits, although attorney visits were still allowed, to July 8, when visitation began to gradually resume prisons. By September 2020, programming with outside facilitators started up again, including drug treatment programs; clergy were allowed back in, libraries re-opened, and some educational and vocational courses started up. On September 28, all prisons opened to family and friend visits. The second lockdown began in November 2020 and lasted six to seven months (depending on the prison). All prisons remained on lockdown until a phased re-opening began on May 1, with all prisons opened to visitation by June 1, 2021. Volunteer-led programming recommenced on August 1, 2021.

31 DOJ 2020, p. 15.

32 Falcon 2021. On the public release of the report see, for example: Schoenberg, Shira, 2021. “Department of Correction moves to end solitary confinement,” *Commonwealth Magazine*, June 29, available at <https://commonwealthmagazine.org/criminal-justice/departments-of-correction-moves-to-end-solitary-confinement/> (visited 2 November 2021).

33 Falcon 2021, p. 30.

34 *Ibid.*

35 *Ibid.*, pp. 32 - 33.

In prisons that experienced outbreaks (which included nearly every prison by time of writing) quarantine units were created, in theory, to separate out COVID-positive people from those who were negative. However, there have been significant variations in how these units were managed. For instance, people awaiting test results (with or without symptoms) were at times housed together in quarantine units.³⁶ In some cases, quarantines were administered differently from disciplinary or other reasons for isolation, but there are reported cases of medical quarantine following similar procedures as disciplinary segregation.³⁷ For example, the Disability Law Center reported that conditions in quarantine units at BSH and OCCC are “akin to or even harsher than those permitted for Massachusetts prisoners in Restrictive Housing per the Criminal Justice Reform Act of 2018, at times providing PS [persons served by a program] hospitalized for evaluation and treatment of serious mental health conditions only one (1) to two (2) hours of out of cell per day.”³⁸

At times, lockdown conditions grew tense and desperate. The entire incarcerated population experienced indefinite periods of being locked inside their housing units with very little to keep them occupied, and under the strain of fear – realized in many cases – of infection. Without programming, the ability to work, and the ability to maintain a network of social relations beyond one’s cellmates, there was little to do except wait for months. Reports emerged of deterioration in the conditions of confinement in terms of the quality of food³⁹ and access to medical and mental health care,⁴⁰ with often dire impacts on people’s mental and physical health – beyond that of the virus. The sheriffs and DOC attempted to mitigate these conditions by instituting limited free calls during periods when visitation was closed due to the pandemic (10 minutes per week in jails and two 20-minute calls per week in prisons). This was a welcome first step, but inadequate countermeasure to the extreme deprivations of movement, programming, and in-person visitation.⁴¹

36 See, for instance, Trounstine, Jean. 2021. “A year of disaster at Old Colony: Suicide attempts self-harm and COVID,” 3 May, available at: <https://digboston.com/a-year-of-disaster-at-old-colony-suicide-attempts-self-harm-and-covid/> (visited 1 November 2021). Similar experiences were conveyed to me directly in interviews with advocates for incarcerated people and formerly incarcerated people; and can be found in grievances filed by incarcerated people. The stories I heard concerned conditions at MCI-Framingham, OCCC, MCI-Shirley and MCI-Norfolk.

37 Disability Law Center [DLC], 2020. “Disability Law Center’s Investigation of MCI-Shirley & MCI-Norfolk,” November 20, available at <https://www.dlc-ma.org/2020/04/30/investigations-of-mci-shirley-and-mci-norfolk/> (visited 2 November 2021).

38 DLC, 2021. “A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served,” July, available at <https://www.dlc-ma.org/wp-content/uploads/2021/07/BSH-Report-7.27.2021.pdf> (visited 1 November 2021), p. 7.

39 See, Doyle, Terrence, 2020. “‘Inedible’ and ‘Inadequate’ Food Is Being Served to People Incarcerated in Massachusetts DOC Prisons,” *Boston Eater*, 7 December, available at <https://boston.eater.com/22153678/food-quality-diminished-incarcerated-people-massachusetts-doc-prisons-pandemic>: (visited 1 November 2021).

40 DLC 2020, p. 7 - 10.

41 Sheriffs allowed for at least 10 minutes of free calls per week (Young, Colin A., 2021. “Massachusetts sheriffs agree to provide inmates with 10 minutes of free phone calls each week, cap on charges above 10 minutes,” *Masslive.com* 22 June, available at <https://www.masslive.com/news/2021/06/massachusetts-sheriffs-agree-to-provide-inmates-with-10-minutes-of-free-phone-calls-each-week-cap-on-charges-above-10-minutes.html#:~:text=Every%20sheriff%20department%20in%20Massachusetts,the%20Massachusetts%20Sheriffs%20Association%20announced> (visited 9 November 2021). The DOC allowed for two free 20-minute calls per week (see EOPS and DOC, 2020. “The DOC’s Preparation and Response to COVID-19,” May, available online at <https://www.mass.gov/doc/the-docs-preparation-and-response-to-covid-19/download> (Visited 9 November 2021), p. 3.

Around the country and in Massachusetts, advocates have raised concern that the processes and conditions of medical quarantine and disciplinary isolation should not be the same.⁴² At the Federal level, legislation has been proposed (HR 2293, the Federal Correctional Facilities COVID-19 Response Act⁴³) to differentiate “medical isolation” from punitive solitary confinement, including by authorizing access to recreational materials, expanded programming and communication privileges for people in medical isolation. However, Massachusetts has not yet similarly addressed the need to distinguish medical from other isolation practices.

These four developments that occurred after the passage of the CJRA, in addition to recognition of the severe mental harms and potentially counter-productive impacts of even 21.5 hours locked in cell, revealed the CJRA’s limits when it came to minimizing use of solitary in Massachusetts. Posing the CJRA’s restrictions as a balanced response to the “dilemma” of the state’s use of solitary within prisons and jails sounded high-minded, yet practical. Rhetorically, it appeared as an attempt to ethically balance the strong evidence that solitary confinement has significant deleterious impacts on a person’s psychological and physical health, creates conditions in which human rights abuses occur, and severs relationships with loved ones that are crucial to rehabilitation, with the fact that serious crimes -- notably, homicide -- can occur inside prison. The reality presents a starkly different picture: the 2018 legislation allowed the DOC and Sheriffs to maintain significant discretion over the use of isolation within prisons and HOC’s, respectively – a discretion they used to maintain the maximal use of solitary just within the limits of the 2018 reform.⁴⁴

In response to mounting pressure, notably following the DOJ and Falcon reports, on June 30, 2021, Massachusetts’ Executive Office of Public Safety and Security (EOPS), which oversees the state’s prisons announced it would end the practice of “restrictive housing.” The change, they announced, would be implemented over the next three years.

However, EOPS did not address how “restrictive housing” would be defined, given current practices, it can be assumed that the MADOC definition is still the 22-hour per day threshold. Further, given the MADOC’s record since 2018, there is no reason to believe that the agency can be trusted to move forward in good faith. They have established a pattern of adopting minimal safeguards and guidelines,

42 Ibid., p. 5. The problem of medical quarantine during the pandemic being implemented in the same units and with the same punitive practices as solitary isolation has been observed at prisons across the country, see also Unlock the Box, 2021. “Letter to the CDC,” February 21. Available at: <https://unlocktheboxcampaign.org/2021/02/12/more-than-100-medical-experts-human-rights-groups-and-faith-organizations-join-unlock-the-box-in-calling-on-the-cdc-to-issue-clear-and-consistent-guidelines-eliminating-the-use-of-prolonged-solitary/> (Visited 1 November 2021). See also American Public Health Association, 2020, “Advancing Public Health interventions to Address the Harms of the Carceral System,” 24 October, available at: <https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2021/01/14/Advancing-Public-Health-Interventions-to-Address-the-Harms-of-the-Carceral-System> (visited 10 November 2021).

43 Introduced by Representative Nanette Diaz Barragán (CA) on April 1, 2021, it has not passed in the House as of time of writing. <https://www.congress.gov/bill/117th-congress/house-bill/2293>.

44 Reflecting conditions nationwide, where there is often significant latitude granted to prison administrators for how a person can get sent to solitary and for how long, but a dearth of clear policy regarding how someone can get out. See “Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey on Time-in-Cell,” The Association of State Correctional Administrators, The Liman Center for Public Interest Law at Yale Law School, available at https://law.yale.edu/sites/default/files/documents/pdf/Liman/asca_liman_2018_restrictive_housing_revised_sept_25_2018_-_embargoed_unt.pdf (Visited 11 November 2021), regarding an uneven, but broad trend nationwide between 2014 and 2018 towards narrowing criteria for placement into and exit from solitary (pps. 60 – 62)

of perpetrating human rights abuses (including unconstitutional abuses) against incarcerated people, and of establishing a profoundly punitive culture within many of the units that house people in conditions of solitary. The EOPS announcement also does not address solitary within the state’s Houses of Correction.

The attempt to mitigate the harms of solitary in 2018 CJRA fell far short.

III. The Harms of Solitary are the Reason Why Reform is Needed

The Commonwealth’s interest in reforming solitary is based on the well-documented and serious harms it inflicts on people subjected to the practice. There is no source more profound or disturbing about the harms of solitary isolation than the testimony of people who have been subjected to it.

Eugene Ivey spent 13 consecutive years in solitary in Massachusetts’ prisons. He was sent to the DDU when he was 24 years old – initially for ten years. He described it as being “locked in a casket alive.” His one hour out of cell was in an outdoor cage, like a dog kennel. Any time he left the cell, he was strip searched. The humiliation of being stripped and examined, of being shackled whenever visitors would come, made him increasingly reluctant to leave the cell, even for the few opportunities granted him, and regardless of the harmful impact of being isolated. He stated: “Your mind plays tricks on you. . . . I would just shut down. . . . In order to feel human, I made the extraction team come in just so I could feel something.” An extraction team, he explained, would use chemical weapons, or shoot rubber bullets. They entered the cell with a shield, rushing in, grappling him to the ground, and piling on top of him. Regardless of the brutality of an “extraction,” Eugene would intentionally provoke guards: “In order to feel human, I had to feel that contact – even though they are pounding on you – I had to have that human contact.”⁴⁵

During testimony at a hearing for the proposed legislation on October 21, 2021, Eugene and several other people who experienced solitary in Massachusetts told their stories. Those who have endured solitary deserve to be listened to with respect and responded to with meaningful legislative reforms. The below review of research is intended to add scholarly and comparative insights to the vivid personal stories demonstrating the harms of solitary isolation.

It is true that a maximum limit of 22 hours locked in cell is a commonly used definition of solitary isolation in the United States. However, this limit is not based on any medical or psychological evidence of reduced harm -- it is merely the result of reforms that attempted to walk back from the draconian permissiveness of locking people in cells for 24 hours a day. The 30 minutes that separate restrictive housing from many other forms of isolation in Massachusetts is meaningless in relation to the types of harms it imposes.

There are no studies addressing what constitutes a “safe dose range” for solitary.⁴⁶ This is because, as Brie Williams and Cyrus Ahalt argue, it would not be possible for researchers to create an experiment testing this question. Given what we already know about the harmful impacts, no research review

45 “Building Justice 2021”, 2021. Prisoners Legal Services, November 23. Available at <https://www.youtube.com/watch?v=A8Rt3QywyA&t=1318s> (Accessed 27 November 2021).

46 Williams, Brie and Cyrus Ahalt, 2020. “First Do No Harm: Applying the Hams-to-Benefits Patient Safety Framework to Solitary Confinement,” in Jules Lobel and Peter Scharff Smith (eds), *Solitary Confinement: Effects Practices and Pathways to Reform* (Oxford: Oxford University Press), 153 – 171, p. 163.

board would approve such an experiment. Using a common public health measure of balancing harm and benefit, Williams and Ahalt note: “In the broader medical and public health research contexts, *any* treatment or intervention with the known risks and lack of demonstrable benefits associated with solitary confinement would be immediately removed from the market and all future research on it discontinued.”⁴⁷ In short, given what is known about the detrimental impacts of solitary isolation there is no reason to, nor would it be deemed acceptable to, engage in further research to determine how much isolation is acceptable.

Legislators should consider whether the state wishes to continue a practice for which is no known “safe dosage,” and which has been found to impose profound harms in four areas:

1. Damage to individual psychological health;
2. Damage to individual medical health;
3. Creation of a “culture of harm”; and
4. Creation of a “community of harm,” described in terms of the detrimental impacts on a wider social network that is isolated from an incarcerated loved one in solitary.

Research evidence of each of these harms is briefly presented below, drawing, where possible, on examples from Massachusetts. I note that most of the research studies cited below define solitary isolation as 22 – 24 hours in cell.

A. Psychological Harm

In 1983, Stuart Grassian, a Board-certified psychiatrist, licensed to practice medicine in Massachusetts and member of the teaching staff of the Harvard Medical School (1974 – 2002), published a ground-breaking study relating his findings from a Court-ordered psychiatric evaluation of 15 men incarcerated at the Massachusetts Correctional Institution at Walpole (later renamed MCI - Cedar Junction).⁴⁸ Grassian found that the men suffered:

- (a) Hyperresponsivity to external stimuli: every sound, smell, and interaction (generally only with Correctional Officers) took on exaggerated meaning and impact;
- (b) Perceptual distortions, hallucinations and derealization experiences: half the men described experiences that blurred the lines of reality: hearing voices, seeing the walls “start wavering or melting”⁴⁹ or believing they were being attacked by guards;
- (c) Extreme anxiety and panic attacks;
- (d) Difficulty thinking, concentrating and remembering;
- (e) Disturbances of thought-content: including aggressive fantasies, paranoia;
- (f) Paranoia;
- (g) Problems with impulse control.⁵⁰

47 Williams and Ahalt, 2020, 165 -166.

48 Grassian, Stuart. 1983. “Psychopathological Effects of Solitary Confinement,” *American Journal of Psychiatry* 140:11, 1450 – 1454.

49 Ibid, p. 1452.

50 Ibid., pp. 1452 - 1453.

Over subsequent decades, many more psychiatric and medical studies have been carried out elsewhere in the US and in other countries, analyzing a wide array of populations subjected to solitary isolation. Overwhelmingly, across time and location, researchers have found significant detrimental psychological impacts when people are held in isolation. Further, as psychologist Craig Haney has reported, double celling under comparable restrictions has a similar impact, and sometimes can be even more detrimental.⁵¹ The below research papers are illustrative:

- A 2006 study found that conditions in solitary were “strikingly toxic to mental functioning, including, in some prisoners, a stuporous condition associated with perceptual and cognitive impairment and affective disturbances.”⁵²
- A 2006 paper reviewed evidence from studies conducted in the 1980s – early 2000s, and found across the board, regardless of often significant variations in solitary conditions, that “a significant percentage of prisoners subjected to solitary confinement suffer from a similar range of symptoms irrespective of differences in the physical conditions in various prisons and in the treatment of isolated inmates.”⁵³ These symptoms included physiological symptoms (severe headaches, dizziness, loss of appetite, digestive troubles, back pain, anxiety attacks); confusion, trouble with memory, and difficulty concentrating; hallucinations, paranoia and illusions; depression, anxiety, anger, self-harm and violent reactions; lethargy, trouble sleeping and suicidal tendencies.
- A 2018 study of formerly incarcerated people found that those who had spent time in solitary isolation were three times as likely to exhibit symptoms of post-traumatic stress disorder than the general population of formerly incarcerated people.⁵⁴
- A systematic review and meta-analysis of existing quantitative studies of solitary isolation was carried out by a group of Canadian psychologists in 2020. They found strong evidence across studies that people who spent time in solitary isolation experienced: increases in mood disorders (anxiety and depression); psychotic symptoms; and aggressivity (hostility and aggression).⁵⁵ Because arguments in favor of using solitary often rest on the need for it in order to respond to aggressive and highly dangerous incarcerated people, it is important to highlight that this form of housing *is associated with an increase in such behavior*.
- These harmful impacts were not by any means limited to people who entered solitary with mental health illnesses. In fact, as Luigi *et al* report, “the association between psychological deterioration and SC exposure grew even stronger when removing a sample entirely composed of inmates with prior mental illnesses”.⁵⁶ In short, solitary *causes* mental illness.

51 Haney, Craig, 2018a. “Restricting the Use of Solitary Confinement,” *Annual Review of Criminology*, 1, 285 – 310, p. 290.

52 Grassian, Stuart, 2006. “Psychiatric Effects of Solitary Confinement,” *Washington University Journal of Law and Policy* 22:325–83, p. 354.

53 Smith, Peter Scharff. 2006. “The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature.” In *Crime and Justice: A Review of Research*, vol. 34, edited by Michael Tonry. Chicago: University of Chicago Press, p. 488.

54 Hagan, Brian O., Emily A. Wang, Jenerius A. Aminawung, Carmen E. Albizu-Garcia, Nickolas Zaller, Sylviah Nyamu, et al., 2017. “History of Solitary Confinement is Associated with Post-Traumatic Stress Disorder Symptoms among Individuals Recently Released from Prison,” *Journal of Urban Health*, 95(2):141–48.

55 Luigi, Mimosa, Laura Dellazizzo, Charles-Edouard Giguere, Marie-Helene Goulet, and Alexandre Dumais, 2020. “Shedding Light on ‘the hole’: A Systematic Review and Meta-analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings,” *Frontiers in Psychology* 11:840, 1 – 11, 7 – 8.

56 Luigi et al, p. 8.

Reviewing the preponderance of evidence that solitary harms people, key professional organizations have likewise concluded that solitary isolation has profound detrimental psychological impacts:

American Public Health Association (2013) issued a statement in which it detailed the public health harms posed by solitary confinement, including that: “[p]risoners in long-term solitary confinement are subject to significant mental suffering and deterioration” and “may develop anxiety, panic attacks, paranoia, cognitive impairment, social withdrawal, somatic symptoms, hypersensitivity to external stimuli, and perceptual disturbances.”⁵⁷ The organization has reaffirmed this position many times in the subsequent years.

The National Academy of Sciences (2014) noted that “there are sound theoretical bases for explaining the adverse effects of prison isolation,” that being housed on a long-term basis in solitary confinement “can inflict emotional damage.”⁵⁸

The National Commission on Correctional Health Care (2016), a professional organization of prison health-care providers, declared that “prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual’s health.” They continued: “the very nature of prolonged social isolation is antithetical to the goals of rehabilitation and social integration.”⁵⁹

Not all studies have found such consistently negative impacts.⁶⁰ Nonetheless, addressing a wide range of studies on solitary confinement, including the few that do not find consistently negative impacts, the National Institute of Justice concluded in 2016 that:

Unfortunately, neither mental health clinicians nor prison officials have a reliable method of determining in advance which prisoners will do well in isolation and which will not. The risk created by this limitation is substantial, and prisoners may be harmed. This risk of harm, combined with the lack of convincing evidence that restrictive housing achieves greater safety and security, requires serious consideration about whether solitary confinement (at least for the purpose of administrative segregation or punishment) serves any useful purpose. Changes to restrictive housing practices will not happen overnight, but substantial reform is encouraged.⁶¹

In short, no major review of the available data on the mental health impacts of solitary confinement conclude that it is safe.⁶²

57 American Public Health Association, 2013. “Solitary Confinement as a Public Health Issue,” 5 November. Available at: <https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2014/07/14/13/30/Solitary-Confinement-as-a-Public-Health-Issue> (Visited 10 November 2021).

58 National Research Council, 2014. *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (Washington, DC: The National Academies), p. 186; cited by Haney 2018, p. 299.

59 National Commission on Correctional Health Care, 2016, “Position Statement: Solitary Confinement (Isolation),” 10 April, available at: <https://www.ncchc.org/solitary-confinement> (visited 10 November 2021).

60 For a critique of a key Colorado-based study that showed little impact of solitary see Haney, Craig, 2018b. “The Psychological Effects of Solitary Confinement: A Systematic Critique,” *Crime and Justice*, 47, 365 - 416.

61 Kapoor, Reena and Robert Trestman, 2016. “Mental Health Effects of Restrictive Housing. NCJ 250321,” in *Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions* (Washington, D.C.: U.S. Department of Justice, National Institute of Justice), p. 223.

62 For a more thorough review of the research and professional standards, see Haney 2018b.

B. Physical Harms

In addition to and often interwoven with psychological harms, people in solitary experience physical impacts from solitary isolation.⁶³ Among these physical impacts are self-harm, including suicide; physical ailments; delayed or ignored medical needs; and increased risk of death from all causes in the year following upon release from prison.

Writing on May 3, 2021, writer Jean Trounstin described the overlapping stories of solitary, mental illness and COVID-19 lockdowns that culminated in a horrific event whereby a man, Joseph Beatty, jumped off the roof of a building, intending to kill himself.⁶⁴ The incident occurred on February 24, 2021, when the men at OCCC were just barely starting to experience some relief in the prison lockdown that had begun months earlier. Since November 2020, they had been locked down with only 30 minutes per day outside of their cells. The men, several of whom that Trounstin spoke with, suffered mental health illness, and had received extremely limited mental healthcare since the lockdown began. Nonetheless, by February over a third of them had contracted COVID-19. One man, Randy Velez, who witnessed the fall, attributed the suicide attempt to long duration of isolation: “Having to deal with being enclosed in a cell for so many hours due to this pandemic will really drive someone off the ledge.”

Velez is correct to point to conditions of solitary isolation as producing suicide ideation and attempts at self-harm. The 2020 DOJ report that investigated “mental health watch” in Massachusetts, found that many examples of self-harm in the state’s prisons. They wrote: “between July 1, 2018 and August 31, 2019, there were 217 instances of cutting, 85 instances of prisoners inserting objects into their bodies, 77 attempted hanging incidents, 34 instances of ingestion of foreign bodies, and 17 attempted asphyxiations, all on mental health watch.”⁶⁵

These examples from Massachusetts are consistent with evidence elsewhere. In New York state, for instance, a study found that suicide rates for people in solitary (between the years 2015 – 2019) was five times higher than that of the general prison population. Further, half of deaths by suicide were young people in their 20s, and 65% of whom were people of color.⁶⁶ Self-harm short of suicide was also high: suicide attempts occurred at rates 12 times higher in “special housing units” than in general population.⁶⁷ Self-harm short of a suicide attempt occurred 7 times more frequently in segregated housing.⁶⁸

In addition to self-harm, studies have also found increased incidence of physical ailments among people in restrictive housing. A study of 363 men in solitary in Washington State prisons found significant increases in complaints about: “(1) skin irritations and weight fluctuation associated with the restrictive conditions of solitary confinement; (2) un-treated and mis-treated chronic conditions associated with the restrictive policies of solitary confinement; (3) musculoskeletal pain exacerbated by both restrictive

63 Luigi, Mimosa, Laura Dellazizzo, Charles-Edouard Giguere, Marie-Helene Goulet, and Alexandre Dumais, 2020. “Shedding Light on ‘the hole’: A Systematic Review and Meta-analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings,” *Frontiers in Psychology* 11:840, 1 – 11, pps. 7 – 8.

64 Trounstin 2021.

65 DOJ 2020, pps. 5 – 6.

66 #HALTsolitary Campaign 2020, “The Walls Are Closing In On Me,” May, available at: http://nycaic.org/wp-content/uploads/2020/05/The-Walls-Are-Closing-In-On-Me_For-Distribution.pdf (visited 10 November 2021), p. 4.

67 *Ibid*, 5.

68 *Ibid* 5.

conditions and policies.”⁶⁹

Another study found a 31% higher hypertension prevalence for people held in solitary confinement compared to those held in maximum security units, with the potential for serious and expensive lifelong medical implications.⁷⁰

Researchers also find patterns of delayed or ignored needs to medical care for people placed in solitary units.⁷¹ The movement into solitary can cause disruption in medical care, even, researchers found, if the care was life sustaining (they note examples of medicines not being administered regularly for kidney problems, seizures, or other chronic and serious conditions). In addition to disruptions in normal care, is the more complicated process of requesting medical help in solitary units, which often include a litany of extra bureaucratic hurdles. The process of seeking care often includes an exchange of deeply personal information shouted through a closed door in a deeply dehumanizing manner that disincentives communication at all.

Higher rates of serious physical impacts do not end with release from solitary. One study of formerly incarcerated people in North Carolina found that people who spent even for as little as 14-consecutive days -- had a 24% increased risk of dying within one year after release from prison (compared to incarcerated people who had not spent time in solitary). The risk increased in relation to how much time a person spent in restrictive housing.⁷²

The medical harms caused by solitary are serious and potentially lifelong. As Strong *et al* conclude: “We find that solitary confinement constitutes not just a mental but also a physical health risk. It exacerbates well-documented physical health “symptoms” of incarceration, from disruptions of daily life and routines, to undiagnosed, untreated, or mis-treated ailments.”⁷³

C. A Culture of Harm

In its 2020 report on the treatment of incarcerated people on mental health watch in Massachusetts’ prisons, the DOJ documented shocking details of cruelty. Below are three examples:

DOJ described an incident where an incarcerated person cut themselves and was bleeding, as guards witnessed what was happening and shrugged off intervention. Not until the person covered their window with a mattress did they intervene. In total, 45 minutes passed between the first cutting incident and when the person, bleeding profusely, was moved out of his cell to a

69 Strong JD, K. Reiter K, G. Gonzalez, R. Tublitz, D. Augustine, M. Barragan, *et al*, 2020. “The body in isolation: The physical health impacts of incarceration in solitary confinement,” *PLoS ONE* 15:10, 1 - 20, p. 1.

70 Williams, Brie A., Amanda Li, Cyrus Ahalt *et al*. 2019. “The Cardiovascular Health Burdens of Solitary Confinement,” *Journal of General Internal Medicine* 34, 1977 – 1980.

71 *Ibid*, 10 – 11.

72 Lauren Brinkley-Rubinstein, PhD; Josie Sivaraman, MSPH; David L. Rosen, PhD, MD; David H. Cloud, JD, MPH; Gary Junker, PhD; Scott Proescholdbell, MPH; Meghan E. Shanahan, PhD; Shabbar I. Ranapurwala, PhD, 2019, “Association of Restrictive Housing During Incarceration With Mortality After Release,” *JAMA Network Open* 2:10, 1 – 11; Pgs. 5 – 6. These findings reflect similar ones from a study of people incarcerated in Denmark, Wildeman, Christopher, and Lar H. Andersen, 2020, “Solitary confinement placement and post-release mortality risk among formerly incarcerated individuals: a population-based study,” *Lancet Public Health* 5, e107 – e113.

73 Strong *et al* 2020, p. 14

hospital for treatment.⁷⁴

Multiple incarcerated people told the DOJ investigators, that “correctional officers verbally taunt them and encourage them to self-harm.”⁷⁵

DOJ also reported that people on mental health watch received “unnecessarily harsh” treatment, including transportation to out of cell activities in leg shackles and handcuffs, and forcing them to wear “security smocks past the time when it was clinically necessary” ...and that such treatment made people feel “inhuman.”⁷⁶

A separate report published by the Disability Law Center (DLC) of Massachusetts revealed a toxic culture. They “received reports of correctional officers in the ISOU making disparaging and even threatening comments to Wellpath Residential Treatment Assistants, interfering with Wellpath-directed activities, and encouraging PS to self-harm.”⁷⁷ DLC also described conditions for people under the DOC’s mental health surveillance at OCCC as “a significantly more intense culture of violence and emergency responses detached from their treatment teams”⁷⁸ when compared to people receiving mental health care under the supervision of medical authorities.

Research on conditions in restricted housing units elsewhere in the country suggests that what was documented in these reports was not unique to Massachusetts, nor is it the quirks of a few people, nor is it a problem of training. Rather, such cruelties are rife in the culture that develops within units where people are severely stripped of their rights and with extreme power asymmetries. In short, dehumanizing conditions enable cruelty.

Two famous research studies have informed understanding of the perpetration of mass atrocities, my primary research field, the Milgram experiment at Yale (obedience to authority) and Stanford prison experiment (dehumanization and abuse of power⁷⁹). While there are limits inherent to the studies and certainly to broader applicability, together they demonstrate how, in an environment where one group of people is held in dehumanizing conditions, the context alters the behavior of those in positions of power. While many questions have been raised especially about the Stanford experiment, in terms of mass atrocities, the insights that quite “normal” people will commit acts of cruelty under certain conditions has been confirmed in subsequent research.⁸⁰

One of the lead researchers on the Stanford Prison experiment was Craig Haney, currently a professor of psychology at University of California, Santa Cruz, and recognized as a leading expert on the psychological impacts of solitary isolation. In 2008, Haney introduced the phrase “cultures of harm” to describe how there is “significant stigma and gratuitous humiliation” associated with institutional contexts in

74 DOJ 2020, 6 – 7.

75 DOJ 2020, 11.

76 DOJ 2020, 17.

77 DLC 2021, p. 16.

78 DLC 2021, p. 17.

79 See *The Stanford Prison Experiment: A Simulation Study on the Psychology of Imprisonment* (website), available at <https://www.prisonexp.org/> (visited 11 November 2021).

80 Waller, James, 2002. *Becoming Evil: How Ordinary People Commit Genocide and Mass Killing* (Oxford: Oxford University Press).

which various forms of solitary are imposed on people. In a follow up article in 2020, he writes:

Prisoners in solitary confinement are enveloped in a “culture of harm” that includes not only the isolating architecture and procedures that the environment, but also the “atmosphere of thinly veiled hostility and disdain [that] prevails.” Interactions with staff are “fraught with resentment and recrimination” and an “ecology of cruelty” subjects prisoners in solitary confinement to the implements of forceful subjugation, including “handcuffs, belly chains, leg irons, spit shields, strip cells, fourpoint restraints, canisters of pepper spray, batons, and rifles,” often wielded by flak-jacketed, helmeted officers.⁸¹

The hyper-militarization and intensively oppositional context of prisons in general, and solitary in particular, is also recognized by those who study it from the perspective of correctional workers. In this discourse, however, the focus shifts from a human rights-based discourse to address stress levels, occupational hazards, and an “us” versus “them” environment. Working in prisons is without doubt highly stressful: correctional officers experience high rates of divorce, heart disease, absenteeism, turnover, and burnout.⁸² The stresses are more intense in units designed for solitary isolation, due to prohibitions on basic everyday interactions between the people (incarcerated and correctional staff), the extreme anger often felt by people within solitary units that is directed against guards, and a “numbing” process that follows. As Jody Sundt argues, “extended exposure to trauma and feelings of disgust may contribute to professional detachment and loss of compassion, causing employees to become numb to emotions or to act out in anger and frustration.”⁸³

This ‘culture of harm’ too often reflects and intensifies broader social inequalities and prejudices, including biases based on race and ethnicity that impact the larger criminal justice system. Multiple studies have found that people of color, notably African Americans, Native American peoples, and Hispanics, experience worse outcomes than white people in criminal justice systems across the country. This is true for Massachusetts as well, as the September 2020 report, “Racial Disparities in the Massachusetts Criminal Justice System” by the Criminal Justice Policy Program, Harvard Law School, stated:

People of color are drastically overrepresented in Massachusetts state prisons. . . . Black and Latinx people sentenced to incarceration receive longer sentences than their White counterparts, with Black people receiving sentences that are an average of 168 days longer and Latinx people receiving sentences that are an average of 148 days longer.⁸⁴

While the Harvard report did not study whether racial and ethnic biases impact treatment once someone is inside the prison system, the Disability Law Center of Massachusetts did find significant discrepancies

81 Haney, Craig, 2020. “The Science of Solitary: Expanding the Harmfulness Narrative,” *Northwestern University Law Review* 115:1, 211 – 256. p. 239). See also Smith, Peter Scharff, 2006. “The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature,” *Crime and Justice* 34:1, 441- 528, p. 474.

82 Sundt, Jody, 2006. “The Effect of Administrative Segregation on Prison Order and Organizational Culture,” (NCJ 250323), in *Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions* (Washington, D.C.: U.S. Department of Justice, National Institute of Justice), p. 315.

83 Ibid, p. 315.

84 Bishop, Elizabeth Tsai, Brook Hopkins, Chijindu Obiofuma, and Felix Owusu, 2020. “Racial Disparities in the Massachusetts Criminal Justice System,” Criminal Justice Policy Program, Harvard Law School September, available at: <https://hls.harvard.edu/content/uploads/2020/11/Massachusetts-Racial-Disparity-Report-FINAL.pdf> (visited 11 November 2021), p. 1.

in two housing units the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU) found at the Bridgewater Units at Old Colony Correctional Center.⁸⁵ They reported a “disproportionate impact on individuals of color caused by systemic inequities in mental health care available in BSH, the OCCC Units, DOC, county correctional facilities, and DMH facilities.”⁸⁶

At present, racial, and ethnic data for use of isolation in Massachusetts is not publicly available, but significant racial and ethnic disparities have been recorded in examples across the country, including:

- A 2020 report by the Liman Center found that African American women were subjected to solitary at higher rates than other groups. Constituting only 22% of the total female prison population (from forty-one reporting jurisdictions across the U.S.), African American women composed 42% of the population in solitary. Black and Hispanic men also experienced solitary at high rates than white men.⁸⁷
- A study examined Florida prisoners who were sent to a supermax prisons from 1996 to 2001 and found that African-American men were 56% more likely to be placed into a supermax prison, where they spent 23 hours locked in a cell, than were white men.⁸⁸
- The New York Civil Liberties Union presented evidence in 2012, that while African Americans composed 14.4% of the state’s population, they were 49.5% of its prison population – and 59% of its population held in extreme isolation.⁸⁹
- Research on the use of solitary in Kansas uses data from 1987 – 2014, with emphasis on the period from 1987 to 1996, found that African American and Hispanic men were sent to solitary more frequently and for longer periods than white men. For young Black adults, the average number of days in solitary was 60, compared with 42 for all incarcerated people.⁹⁰

Disparities in outcome are not necessarily the same as disparities in process, but there is no question that the former (troubling in its right) raises a glaring warning flag concerning the latter.

Broader social power imbalances and prejudices play out in placement into solitary are also evident in how the practice is used for incarcerated women. A 2018 investigative report by NPR and the Medill School of Journalism at Northwestern University, that included prison visits and data gathering efforts, found that in 13 of the 15 states analyzed, women get in trouble at higher rates than men. Their analysis of data from Massachusetts found that “60 percent of punishments for women restricted where they could go in prison, including confinement to their cells. Men received those punishments half as often.”

85 DLC 2021, p. 5.

86 Ibid.

87 Correctional Leaders Association/Arthur Liman Center for Public Interest Law at Yale University, 2020. “Time-in-Cell 2019: A Snapshot of Restrictive Housing,” available at https://law.yale.edu/sites/default/files/area/center/liman/document/time-in-cell_2019.pdf (visited 12 November 2021), p. 26

88 Mears, Daniel P., and William D. Bales, 2010. “Supermax housing: Placement, duration and time to re-entry,” *Journal of Criminal Justice* 38, 545 – 554, p. 551.

89 Kim, Scarlet, Taylor Prendergrass and Helen Zelon, 2012. “Boxed In: The True Cost of Extreme Isolation in New York’s Prisons,” New York Civil Liberties Union, available at <https://www.nyclu.org/en/publications/report-boxed-true-cost-extreme-isolation-new-yorks-prisons-2012> (Visited 11 November 2021), p. 24

90 Sakoda, Ryan T., and Jessica T. Simes, 2021. “Solitary Confinement and the U.S. Prison Boom,” *Criminal Justice Policy Review*, 32:1, 66 – 102, p. 81.

Across the board, the women tended to get punished for minor infractions at much higher rates than males, even in cases where infractions result in serious punishments, like solitary.⁹¹

Solitary isolation creates a toxic culture, where cruelties are enabled. This culture of harm also reflects and amplifies disparities found through society.

D. Communities of Harm

Solitary isolates not only the person subjected to it, but also the family and loved ones of an incarcerated person – who often lose the possibility for in-person contact and encounter difficulties gaining even minimal updates about an incarcerated loved one’s whereabouts and condition. To capture this element of harm, I draw on the work of feminist legal scholar, Finnoula Ni Aolain, who has argued that “violations not only destabilize the person(s) toward whom the acts are directly intended but a wider circle whose own autonomous entitlements are precariously in balance with the well-being and safety of others.”⁹² In short, when we wish to account for the harmful impact of policies, we should not only include the person directly impacted, but also the ways human rights abuses ripple through a community.

In the case of solitary isolation, the community includes the families and loved ones of an incarcerated person. A survey in Michigan by Citizens for Prison Reform⁹³ interviewed 30 families who had a loved one placed in restrictive housing. The family members describe sudden and unexplained disappearance of their loved one from communications – calls, emails, and/or letters. Several families stated that they only learned what happened from another incarcerated person or after multiple calls to the prison. The study found that 85% of family members could no longer visit their loved one. The absence or extreme limitations on calls were especially difficult on children.⁹⁴ Further, the psychological and physical impacts of having a loved one placed in solitary spilled over into the family members:

Nearly all family members said that they were extremely anxious, scared, and worried for their loved ones’ safety and wellbeing while in segregation. For some, this constant state of worry led to diagnosed anxiety disorders, depression, panic attacks, and deep loneliness. [...] members are literally “worried sick” over their loved ones in segregation, experiencing stress-related physical conditions such as arrhythmia, chest pains, cracked teeth, TMJ, insomnia, nightmares, and an inability to concentrate or work.⁹⁵

The concerns expressed by family members in Michigan resonate with those experienced by families in Massachusetts.⁹⁶

91 Shapiro, Joseph, Jessica Pupovac, and Kari Kydersen, 2018. “In Prison, Discipline Comes Down Hard on Women,” *National Public Radio*, available at: <https://www.npr.org/2018/10/15/647874342/in-prison-discipline-comes-down-hardest-on-women> (visited 11 November 2021).

92 “Sex-based Violence and the Holocaust: A Re-evaluation of Harms and Rights in international Law,” *Yale Journal of Law and Feminism* 2000, 12:43, 43 – 84, page 77.

93 Citizens for Prison Reform, 2020. “Solitary: The Family Experience,” available online at http://www.micpr.org/uploads/8/9/7/1/8971956/solitary_the_family_experience_final-compressed.pdf (Visited 11 November 2021).

94 *Ibid*, 16.

95 *Ibid*, p. 17

96 See, for example, on family members frustrations in trying to advocate for continuity of care for incarcerated loved ones with mental health illness, DLC 2021, 18 – 19.

Unsurprisingly, the community may also extend to harm people who work in solitary units and their broader social networks as well. In research on PTSD among Correctional Officers in Michigan, researchers included:

...emerging evidence suggests that prisons comprise such toxic environments that they have adverse effects on even the correctional officers who work there, including on their health and behavioral health risks, including domestic violence and suicide. In response to this growing literature, many (though not all) correctional leaders have expressed doubt that solitary confinement leads to any benefit and instead have raised the possibility that working in such units also harms staff.⁹⁷

The cumulative effect of these four areas of harm – psychological, physical, environment of cruelty, and communal harms – substantiate why we must view solitary isolation as torture. It also clarifies why all forms solitary isolation need to be very closely monitored and regulated.

IV. Reform in comparative context

There is slow, uneven movement internationally and nationally to abolish the use of solitary isolation – particularly any usage that exceeds 15 days, a limit arrived at through discussions that led to the creation of the Mandela Rules. However, as it discussed below, in the United States this reform has not primarily occurred through judicial review, but only through legislative action. Massachusetts has a chance to take such action, with a strongly worded bill currently sitting in Committee.

A. *International Standards*⁹⁸

Internationally, the key standard that governs solitary isolation is the 2015 “Mandela Rules,” United Nations Standard Minimum Rules for the Treatment of Prisoners of 2015. It defines solitary as: “the confinement of prisoners for twenty-two hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of fifteen consecutive days.”⁹⁹ Any form of indefinite or prolonged solitary confinement is prohibited under these Rules. Further, the Rules argue that solitary confinement should be used only in “exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority.” The Mandela Rules also limit solitary for women and children, people with mental or physical disabilities.

These guidelines are not separable but must be understood as functioning together. Thus, one cannot simply apply the limit of 22 hour per day in cell, without also taking into consideration the impetus to not exceed 15 consecutive days, and to use solitary only as a last resort.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, issued by the Council of Europe, predates the Mandela Rules, and stipulated that all uses of

97 Williams and Ahalt 2020, p. 165.

98 I wish to thank Emilia Gmitter for her research on international standards which informs this section.

99 United Nations Standard Minimum Rules for the Treatment of Prisoners (The Nelson Mandela Rules), adopted unanimously by the UN General Assembly in Res. A/ 70/ 175 of 17 December 2015, Rule 44.

solitary, “must be proportionate, lawful, accountable, necessary and non-discriminatory.”¹⁰⁰ Other measures in Europe have been attempted to impose restrictions on the use of solitary (defined as 22 hours or more locked in cell), by imposing guidelines about who should not be subjected to solitary, the need for regular medical reviews, a requirement to provide reporting on its use at each prison, and directing prison administrators and member countries to limit its use to “exceptional cases,” only for a specific period of time, which should be as short as it possible.¹⁰¹ While the European guidelines left discretion to member states, countries in Europe do not allow the use of solitary for more than two weeks.¹⁰²

A key question of whether and under what conditions solitary isolation might be considered torture is addressed – albeit incompletely – in the United Nations Convention Against Torture Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).¹⁰³ The relevant section of Art. 1.1, which defines torture as an:

“[A]ct by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person [...] for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”

Subsequently, UN Special Rapporteurs on Torture addressed solitary in more detail. In 2011, the Special Rapporteur Juan Mendez issued a report calling on states to prohibit indefinite solitary confinement and solitary confinement exceeding 15 consecutive days. He urged states to prohibit imposition of this measure as punishment (as a court ordered sentence or a disciplinary measure) and recommends developments of alternatives.¹⁰⁴ And in 2021, the Special Rapporteur, Nils Melzer, cautioned: States that permit solitary confinement in domestic law cannot invoke prolonged and indefinite solitary confinement as “lawful sanctions,” all sanctions must interpreted in line with Mandela Rules.¹⁰⁵

B. Reform in the US

Reforming solitary isolation in the United States has primarily been spearheaded by the social activism – much of it led by people who are directly impacted by criminal justice systems -- and state legislatures. Judicial review has made only very limited, procedural inroads.¹⁰⁶ As Resnick et al argue, “judges

100 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [CM(2011)162], Council of Europe, 7 December 2011, para. 55.

101 Council of Europe, Recommendation Rec (2006)2-rev of the Committee of Ministers to member States on the European Prison Rules (Revised and amended on 1 July 2020).

102 See, European Union Agency for Fundamental Rights, “Criminal Detention in the EU: Conditions and Monitoring,” available at: https://fra.europa.eu/en/databases/criminal-detention/criminaldetention_search?search_api_views_fulltext=solitary+confinement (visited 12 November 2021).

103 UN General Assembly, *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 10 December 1984, United Nations, Treaty Series, vol. 1465, p. 85, available at: <https://www.refworld.org/docid/3ae6b3a94.html> [accessed 12 November 2021].

104 “Torture and other cruel, inhuman or degrading treatment or punishment,” A/66/268, 5 August 2011.

105 “Torture and other cruel, inhuman or degrading treatment or punishment,” A/HRC/46/26, 22 January 2021, para 13.

106 Resnick, Judith, Hirsu Amin, Sophie Angelis, Megan Hauptman, Laura Kokotailo, Aseem Mehta, Madeline Silva, Tor Tarantola, and Meredith Wheeler, 2020. “Punishment in Prison: Constituting the ‘Normal’ and the ‘Atypical’ in Solitary and Other Forms of Confinement,” *Northwestern University Law Review* 115: 45, 45 - 158, p. 155. Reinert, Alexander, 2018.

licensed officials to alter in profound ways the quantum of punishment imposed,”¹⁰⁷ adding only limited protections, as best. They have not taken seriously the degree of harm imposed by the practice – despite compelling evidence.

Reform has nonetheless progressed, with a few states like Colorado (which limits time in cell to 22 hours a day, not to exceed 15 consecutive days) and New York (defines solitary as any form of cell confinement more than 17 hours a day, not to exceed 15 consecutive days), and New Jersey (limits to 20 hours a day, and not to exceed 20 consecutive days) in the lead. Across the country, legislators have begun to tackle solitary with increasing alacrity: From 2018 to 2020, legislation to limit the use of isolation in prison was introduced in more than half the states and in the U.S. Congress.¹⁰⁸

Following a long and hard-fought social justice movement led by #HALTsolitary (a civil society organization), New York passed legislation in 2020 (comes into effect in April 2022) that set a new standard in limiting the use of solitary confinement for everyone in prison, not just special categories of people who had benefitted from previous periods of reform (pregnant women, juveniles, people suffering from mental illness). The new guidelines for all incarcerated people included: confinement in cell for no more than 17 hours per day, and specific out of cell requirements; solitary may be imposed only 3 consecutive days or six total days within a 30-day period, unless someone has been accused/found guilty of a serious violation (which are specified in the legislation). In that case, the time restrictions are no more than 15 consecutive days and nor more than 20 total days within a 60-day period. The legislation added to the protected groups who cannot be placed in solitary: anyone 21 or under, someone with a disability, serious mental illness, pregnant or postpartum, or caring for a child in prison. It imposed regular reporting requirements regarding everyone who is placed in solitary.

In an administrative move that issues a warning flag for legislators, New York City responded by drafting new rules that allowed for “time out of cell” to include release to an adjacent cell.¹⁰⁹ The push and pull movement whereby legislators enact reform and administrators endeavor to maintain solitary at the maximal level possible has been repeated across the country.¹¹⁰ And, as documented above, it has also occurred in Massachusetts.

C. Massachusetts’ Proposed New Legislation

Massachusetts has already expressed its commitment to reducing the use of solitary. The DOC has recognized that restrictive housing is no longer deemed an acceptable practice and pledged to end it. Legislation proposed in 2021 aims to solidify the parameters that govern the use of solitary and to

“Solitary Troubles.” *Notre Dame Law Review* 93:3, 927 – 976, p. 941.

107 Resnick et al, 155.

108 Resnick, Judith, 2021, “Legislative Regulation of Isolation in Prison,” testimony submitted re: An Act Amending Title 61 (Prisons and Parole) of the Pennsylvania Consolidated Statutes, providing for solitary confinement,” available at: <https://www.senatormuth.com/wp-content/uploads/2021/08/Judith-Resnik.pdf> (Visited 12 November 2021), p. 10.

109 See #HALTsolitary, 2021. “NYC End Solitary Community Sign-On Letter,” 1 August. Available at <http://nycaic.org/wp-content/uploads/2021/08/NYC-End-Solitary-Community-Sign-On-Letter-Aug-1-2021.pdf> (visited 12 November 2021); Kupers, Terry Allen, 2021. “Solitary Confinement by Any other Name is Still Solitary, and Needs to End,” 6 August, available at: <https://citylimits.org/2021/08/06/opinion-solitary-confinement-by-any-other-name-is-still-solitary-and-needs-to-end/> (Visited 12 November 2021);

110 Rubin, Ashley T. and Keramet Reiter, 2018. “Continuity in the Face of Penal Innovation: Revisiting the History of American Solitary Confinement,” *Law & Social Inquiry* 43:4, 1604 – 1632.

unify the treatment of incarcerated people within Massachusetts. It provides eight primary new measures towards ending solitary in Massachusetts. Among the key improvements included in this bill are:¹¹¹

- 1. Expansion of the CJRA protections to all segregated confinement:** all units that are segregated from the general prison population are protected by the provisions of the CJRA, regardless of how they are defined.
- 2. Creation of baseline conditions protections in general prison population:** ensures that general population units cannot have similar or worse restrictions than segregated confinement, that no one in general population is locked in their cell for more than 16 hours a day, and that all incarcerated people have access to baseline programming entitlements.
- 3. Improved mental health care:** people who are designated as having a serious mental illness may only be placed in general population or a secure treatment unit which meets minimum standards for mental health treatment, programming, and education, and has a minimum of 5 hours out-of-cell time daily. The house version of the bill also establishes that a clinical staff person will be the director of all secure treatment units, while correctional staff is responsible for security.
- 4. Improved mental health watch:** establishes a maximum of 72 hours for mental health watch, after which a person would need to be transferred to an outside hospital for appropriate treatment if needed. Further, it mandates that prisoners on mental health watch have out of cell time, be fully clothed, provided blankets, and menstruating prisoners be provided with personal hygiene supplies.
- 5. Clarification and enhancement of rights** to out of cell time, visitation, television and radio, canteen access, and disability accommodations.
- 6. Expanded protections for vulnerable populations:** prohibits any form of segregated confinement, regardless of how it is defined, for pregnant and post-partum prisoners, prisoners with permanent physical or developmental disabilities, prisoners 21 years old or younger or 55 or older.
- 7. Due process protections:** enhances procedural protections for incarcerated people who are segregated from the general population and establishes an appeals process to the Superior Court. The bill also ensures that if a prisoner is in solitary confinement awaiting a disciplinary hearing, they must return to the general population in no later than 15 days. The house version of the bill further provides that disciplinary sanctions cannot exceed 15 days in segregated confinement.
- 8. Improved data and oversight provisions:** improves and enhances data reporting requirements and the rights and responsibilities of the restrictive housing oversight committee.

111 Full language of the legislation is available at <https://malegislature.gov/Bills/192/H2504> (visited 12 November 2021). This summary is from materials created by the MASC.

V. Conclusion

Prisons and jails are horrible places: they impose constant surveillance, restrictions of movement and rights. They separate families and force people to identify as a number within a system. They dehumanize by nature. Prison is – without any further deprivations -- a painful punishment for those convicted of crimes; and jails play the same role. There is no question that our prisons hold some people who have committed serious crimes and there is no doubt that working in a prison is dangerous. But prisons and houses of correction should not add additional punishments that take the form of torture by subjecting people to solitary isolation without meaningful and measurable safeguards.

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