American Psychiatry Should Join the Call to Abolish Solitary Confinement

Kenneth L. Appelbaum, MD

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> A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community.[1]

One hundred twenty-five years ago, the U.S. Supreme Court had already noted the harmful effects of solitary confinement, as the above quote attests. A spate of published papers in the last half of the 19th century on the psychological damage experienced by isolated prisoners contributed to the practice's falling out of favor.[2–4] Despite the well-known consequences of solitary confinement, recent decades have seen a dramatic surge in the number of inmates subjected to prolonged and extreme isolation in the United States. Reliable data on actual numbers and trends are difficult to obtain, in part because of the differences in terminology used by correctional systems and the absence of systematic tracking. Government and other reports, however, offer some insight. Analysis of data compiled by the Bureau of Justice Statistics (BJS) found a 68 percent increase in the number of inmates in disciplinary segregation from 1995 through 2000, more than double the growth of the overall prison population, with 70,000 in administrative or disciplinary segregation and another almost 11,000 in segregation for protective custody.[5] A similar analysis of 2005 BJS data found that over 80,000 of the nation's 1.3 million inmates incarcerated in state or federal facilities were in segregated restricted housing.[3,6] These statistics likely understate the use of segregation in the United States because they do not include individuals held in jails, immigration detention centers, military facilities, or juvenile detention facilities. A 2013 report from the United States Government Accounting Office (GAO) had similar findings in the Federal Bureau of Prisons (BOP), which held about 7 percent of its 217,000 inmates in segregated housing units.[7] According to the GAO report, from 2008 through 2013, the overall number of inmates in BOP segregated housing increased approximately 17 percent compared with an increase of only 6 percent in the total inmate population. At the end of 2013, the United States held an estimated 1,547,700 inmates in state and federal prisons.[8] Research reported by the Vera Institute of Justice in 2015 found that state prison systems had from five to eight percent of their inmates in segregated housing.[9] These rates suggest that the United States has between 75,000 and 120,000 inmates in segregation in state and federal facilities alone, although an unknown proportion of these inmates likely reside in conditions that would not qualify as solitary confinement as defined in this article. Even with recent efforts by a handful of states to reduce their reliance on segregation, its use in the United States remains considerable, regardless of the precise number of inmates involved.

Although much of the rest of the world has pulled back from placing prisoners into extreme isolation,

Dr. Appelbaum is Clinical Professor of Psychiatry and Director, Correctional Mental Health Policy and Research, Center for Health Policy and Research, Commonwealth Medicine, University of Massachusetts Medical School, Worcester, MA. Address correspondence to: Kenneth L. Appelbaum, MD, Center for Health Policy and Research, 333 South Street, 13E483, Shrewsbury, MA 01545. E-mail: kenneth.appelbaum@umassmed.edu.

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the United States mostly has not. Our nation's jails and prisons have become a bastion for conditions widely eschewed elsewhere. Although a groundswell of opposition has arisen, the American Psychiatric Association (APA) has yet to join unequivocally in the call to abandon this harmful practice for all inmates. Instead, the formal position statement of the APA limits its call for restrictions to those inmates with serious mental illnesses. As the preeminent mental health professionals, psychiatrists should be in the lead, not on the sidelines, of the campaign against the use of prolonged segregation, regardless of diagnostic status. I will examine the evidence showing that solitary confinement is unnecessary and counterproductive for security and a risk to the mental and physical health of inmates. The APA's qualified call to limit the practice among inmates with serious mental illness stands in stark contrast to demands for broad elimination expressed by an array of other organizations.

Definition

We must begin with a definition. In my experience, prison administrators often eschew the use of the term solitary confinement and bristle at the suggestion that this is what they do. They refer to the isolation of inmates as "segregation," even when it involves being locked in a small cell for 23 hours or more per day without opportunity to interact with others and without access to facility programs such as educational or work activities. Other deprivations can include restricted or prohibited visitation; limited, if any, natural sunlight; and the absence of diversions, such as radio, television, books, and magazines. Even the one hour spent out of cell generally consists of solitary exercise in a narrow cage that resembles a dog run. These conditions of segregation do not differ from those of solitary confinement, and I will use the terms interchangeably.

For purposes of this discussion, the definition of solitary confinement or segregation does not include isolation for medical reasons (e.g., infectious diseases), therapeutic seclusion, periods of voluntary withdrawal (e.g., while coping with bereavement), or protective-custody settings where inmates may be separated from the general population for safety reasons but without extreme conditions of isolation and lockdown. Nor does it include settings where inmates have greater access to programs, diversions, out of cell activities, and interactions with others. As part of a recognized clinical standard of care, an increasing number of correctional systems provide such improved conditions for inmates with serious mental illnesses who would otherwise be in solitary confinement.[10] Although systems that provide these enhancements might still label these settings as segregation units, the conditions do not qualify as solitary confinement or segregation, as usually defined and as described in this article.

Arguments in Support

The arguments in support of solitary confinement fall into three main categories: it ensures the safety of the inmate and others, it can effect behavioral change, and it is a punishment for infractions.

Safety

The foremost contention in support of solitary confinement is that it is necessary for safety. Segregation can be imposed for disciplinary reasons after a rule infraction or for administrative reasons, such as when the inmate is deemed to be a potential threat. Some inmates certainly require intensive security measures because they pose risks of serious harm to other inmates and to staff. Many, if not most, inmates housed in segregation units, however, are not assaultive. The National PREA (Prison Rape Elimination Act) Resource Center (NPRC), a joint project of the federal Bureau of Justice Assistance and the National Council on Crime and Delinquency, issued a report in April 2015 that stated, "Originally intended to handle dangerous inmates and those who had committed very serious infractions, over time, the use of segregated housing expanded to include a high proportion of individuals with violations that are disruptive but not violent."[11] In 2012, for example, South Carolina made it a Level 1 offense for inmates to access social networking sites, either directly or through password-sharing with family or friends. Since its implementation, this policy has led to more than 400 disciplinary cases, with over 40 inmates receiving sentences of more than two years in solitary confinement.[12] One inmate who had 35 posts made to his Facebook page received a cumulative sentence of more than 37 years in segregation, along with loss of telephone, visitation, and canteen privileges for the next 74 years. Nonviolent disciplinary offenses that can result in solitary confinement in other states include failure to stand for a count, being out of place, failure to report to work or school, re-

fusing to participate in programs, unexcused absence from work, talking disrespectfully to a correctional officer, and failure to obey an order.[3,11] The correctional administration in Mississippi recently acknowledged that "many of the people we were holding in segregation were not a threat," but they could end up in segregation for years for nonviolent "minor violations" such as "vulgarity toward staff."[13] During a one-year period in Illinois, more than 85 percent of inmates coming out of disciplinary segregation had been there for such minor infractions and, in Pennsylvania, the most common reason for segregation was "failure to obey an order," with a sentence imposed 85 percent of the time for this infraction.[9] Both of these states have started to put some limits on punishments for minor infractions (e.g., taking unauthorized food from a dining hall), but in many states, nonviolent infractions still result in segregated housing for months, years, or decades.[9] "Nuisance" behaviors may even result in placement in supermaximum security (supermax) prisons,[14] with confinement in these facilities deemed overused by some nationally recognized experts in correctional mental health.[10] Not every misuse of disciplinary sanctions rises to these levels of absurdity, but many inmates in solitary confinement are there for reasons no more violent than allowing family or friends to make mundane updates to their social media profiles. Safety concerns cannot justify their placement and continued stay in isolation.

Seemingly minor and nuisance offenses could occur in conjunction with behaviors that do threaten institutional security and safety, but in addition to the national findings and statements by corrections officials noted above, several observations also make it unlikely that major security considerations underlie the typical use of solitary confinement for these offenses. If inmates were arranging for Facebook page updates that involved threatening or intimidating statements, for example, the resulting charges would likely reflect this infraction, and the same would be true if disobedience of an order occurred in conjunction with threats, assaults, escape attempts, or other substantial security concerns. Although correctional systems typically have a range of graduated sanctions for disciplinary infractions, solitary confinement can be their first and their go-to response.[5,9] The disproportionate growth in the number of segregated inmates is consistent with a lowering of the threshold for imposition of solitary confinement. Although Alcatraz has been recognized as the forerunner of the supermax prisons, the large-scale construction of today's supermax prisons beginning in the 1970s[15] also led to a need to fill them by overclassification of inmates for minor, nonviolent disciplinary infractions, for suspected gang membership in the absence of any misconduct, or for similarly loosened criteria.[16] One commentator referred to this as "build it and they will come" when describing the rapid filling of an expanded number of segregation cells in a facility that had no previous backlog or waiting lists and no change in inmate composition or prison climate.[17] A survey of administrative segregation policies in 44 states plus the federal bureau of prisons found that, while all of them mention safety and security as the primary goal, they allow broad discretion that permits placement in segregation for reasons other than incapacitation. This approach can result in "overuse based on what is colloquially known as being 'mad' at a prisoner."[18] The same "wide discretion" applies to disciplinary sanctions in which "extreme isolation is too frequently used as a disciplinary tool of first resort."[19] In addressing this, the Commissioner of the New York State Department of Corrections and Community Supervision, Brian Fischer, has acknowledged, "I'll be the first to admit—we overuse it."[19]

Equally unnecessary use of solitary confinement can occur for other nondisciplinary reasons, such as protective custody for individuals vulnerable to abuse in general-population settings. The NPRC report found that "Inmates with serious mental illness and those with developmental disabilities are among the populations who are often placed in segregated housing for protection . . . in units with the same intensive security procedures, levels of isolation, restricted human interactions, and reduced access to programs" despite having no violations or threats to staff or others (Ref. 11, p 5). I have surveyed facilities that routinely use ongoing solitary confinement, purportedly for protective custody, for all inmates identified as transgendered. They enforce this policy in the absence of disciplinary problems or requests by the individual for protection and in disregard of the significant depression and suicidality that occur in the inmates. These facilities impose the full conditions of solitary confinement on these inmates, including cuffing and shackling them whenever they come out of their cells. Repeated complaints have been filed by immigration detainees in the United

States and their advocates alleging "solitary confinement based solely on the sexual orientation or gender identity" of the detainee (Ref. 20, p 5). The use of solitary confinement solely for protective custody of immigration detainees who have committed no crimes, in response to their sexual orientation or mental illness, has also been described in the press[21] and documented by human rights organizations that have found that "vulnerable immigration detainees, including members of the LGBT community, religious minorities and mentally challenged detainees . . . spend a significant portion of their time in solitary confinement ('administrative segregation') and are allowed out of their cells for an hour every day" (Ref. 22, p 104). Protective custody is an important option for some vulnerable inmates, and it necessitates a degree of separation from general-population inmates, but it does not require or justify placement into solitary confinement. Not every facility or system puts inmates into solitary confinement for protective custody, but those that do should stop the practice.

For the remaining inmates in segregation who represent a risk of harm to others, a growing body of experience refutes the contention that deprivation of meaningful human interaction is necessary for safety. A 2003 study sponsored by the National Institute of Justice concluded that imposing segregation-like extreme restrictions on inmate movement and interaction "as a mechanism to enhance prison safety remains largely speculative" (Ref. 23, p 1341). Use of prolonged solitary confinement can actually compromise safety in institutions and in the community upon release. In 2006, a blue ribbon national commission on prison safety co-chaired by a former Attorney General of the United States and a former Chief Judge of the U.S. Court of Appeals for the Third Circuit concluded that, "[T]he increasing use of high-security segregation is counter-productive, often causing violence inside facilities and contributing to recidivism after release" (Ref. 5, p 14). Top administrators in correctional systems that have eliminated or significantly reduced the use of solitary, such as Maine,[24] Minnesota,[25] Mississippi,[13,26] and the United Kingdom,[27] have acknowledged improvements in safety, often to their surprise. After reducing its use of segregation by up to 85 percent, Colorado has reportedly experienced its lowest rate of prisoner assaults on staff since 2006.[9] Germany and the Netherlands limit the annual use of solitary confinement for an inmate to four weeks and two weeks, respectively and, in practice, use it extremely rarely and for only a few hours at a time.[28] According to a statement to the British Broadcasting Company (BBC) from the Prison Service of England and Wales, "At any one time there would only be a small handful of exceptionally dangerous prisoners held in these conditions (under five) . . . prisoners are never left in an isolated state for long periods of time."[29] More and more correctional systems in this country have eliminated solitary confinement while maintaining safety for inmates with serious mental illness, even for those properly classified for supermaximum security.[10] These inmates may remain in settings of enhanced security without imposing extreme isolation and other deprivations. The same principles and reforms can be applied for all inmates.

Behavioral Change

Punishment with the goal of changing behavior provides a second potential justification for solitary confinement. As a technique for modifying behavior, however, punishment is the least effective and most likely to boomerang and make matters worse. The observations that solitary confinement can increase assaults and injuries demonstrate its ineffectiveness. Real and lasting change is more likely to occur by teaching and rewarding desired behaviors.

The techniques for shaping behavior are complex and include many strategies. For example, both positive and negative reinforcement can increase the likelihood of a desired behavior. In positive reinforcement, the individual receives a reward for the behavior, and in negative reinforcement, the behavior results in relief from or removal of something unpleasant. Correctional policies in Germany emphasize positive reinforcement and severely restrict the use of solitary confinement.[28] In contrast to techniques that encourage desired behaviors, other strategies, such as extinction or punishment, focus on discouraging undesirable behaviors. Extinction involves removal of a sought-after result that the individual has gained by engaging in unwanted behavior. The behavior diminishes or becomes extinct when it ceases to be rewarded. Segregation as a form of behavior modification, however, does not rely on reinforcement or extinction. Instead, it involves punishment: the unwanted behavior results in an unpleasant consequence. The punishing consequence may include either imposition of something aversive (positive punishment) or removal of something the

individual values (negative punishment). Segregation contains elements of both positive and negative punishment, as it places inmates in a setting that many find unpleasant at the same time that it deprives them of access to more agreeable settings and activities.

Each behavioral technique has advantages and limitations. Although punishment sometimes works, it typically has the greatest limitations to success. For example, it works best when applied immediately and consistently. Delays between the behavior and the punishment or the failure to punish every instance of the behavior can significantly diminish effectiveness. In addition, punishment often results in only temporary changes. Punished behaviors tend to reappear when punitive consequences disappear. Unintended and detrimental results also occur, such as increases in aggressiveness and antisocial behaviors in response to physical punishment. Prisons that emphasize control and rely on punitive sanctions have been found to have higher rates of disorder than facilities that encourage inmate responsibility and provide opportunities for self-governance.[30] If behavioral change is the goal, punishment through segregation is a blunt and relatively ineffective tool.

Punishment

A third, often unspoken, motivation for imposing solitary confinement involves vengeance or payback. Punishment is used as an end unto itself, rather than as a means of effecting changes in behavior. In many instances, punishment is the primary motivation for putting inmates into segregation. When inmates misbehave, they are made to suffer regardless of whether alternative responses would lead to better behavioral outcomes. In these instances correctional officials use segregation precisely because it is punitive and painful. The psychological distress and suffering caused by solitary confinement is the reason for doing it, not an unintended side effect. If this is the goal, the practice all too often succeeds.

Adverse Effects

If concerns about the use of solitary confinement involve questions about its efficacy in enhancing safety or in extinguishing undesirable behaviors, why should psychiatrists care? Institutional safety and rule infractions are primarily under the purview of correctional custody officials. We might consider their approach ill-advised from a disciplinary perspective, but that is not reason enough to advocate for changes. If compelling mental health contraindications exist, however, we cannot remain disinterested bystanders.

Social relationships play a crucial role in maintaining well-being and health for humans and other social species.[31] An extensive body of research in animals and humans since at least the 1970s has repeatedly shown the adverse psychological and physiological effects, including increased mortality, of social isolation in noncorrectional settings.[31–33] Isolation has risks of morbidity and mortality comparable with those associated with smoking, obesity, sedentary life style, and high blood pressure.[31,34] Physiological effects of isolation in humans and other social animal species include increased sympathetic tone; activation of the hypothalamic-pituitary-adrenal axis; altered glucocorticoid regulation; and decreased inflammatory control, immunity, and sleep quality.[35] Some adverse health effects can persist long after the isolation ends.[32,36]

In addition to social isolation, solitary confinement almost always occurs in settings that severely limit access to sunlight, fresh air, and exercise. These deprivations have their own independent adverse effects on physical and mental health.

Why would we think that inmates would be immune to these adverse effects? The literature on the "psychological, psychiatric, and sometimes physiological effects" of solitary confinement has been described as "sizable and impressively sophisticated" (Ref. 37, p 441). A recent review stated that "[n]early every scientific inquiry into the effects of solitary confinement over the past 150 years has concluded that subjecting an individual to more than 10 days of involuntary segregation results in a distinct set of emotional, cognitive, social, and physical pathologies" (Ref. 4). A 2014 report by the National Academy of Sciences concluded that "[a]n extensive empirical literature indicates that long-term isolation or solitary confinement can inflict emotional damage,"[38] and the NPRC describes "increasing evidence" that solitary confinement "can create or exacerbate serious mental health problems and assaultive or anti-social behavior, and lead to decreases in physical health and functioning" (Ref. 11, p 6).

Most of the literature, however, has methodological limitations and inconsistencies in the conditions being studied. Some reviewers of the literature have come to the unsurprising conclusion that the nega-

tive effects of administrative segregation occur primarily in settings that do not meet basic standards of humane care, although we are as yet unable to predict which individuals will cope poorly based on their individual characteristics.[17]

The study that has probably received the most attention for its finding that segregation did not cause extreme harm to inmates can serve as an example of possible challenges in research methodology and the importance of environmental conditions. Researchers in Colorado studied the psychological symptoms of inmates in administrative segregation and found that most of them did not deteriorate and some showed improvement over time.[39] As other commentators have pointed out, however, the Colorado study did not examine the effects of solitary confinement.[40] The Colorado administrative segregation unit, as one author of the study noted, "has a combination of features that was not present in the supermax prisons where experts concluded the conditions produced psychological deterioration among prisoners who had not previously been mentally ill" (Ref. 41, p 6). The Colorado inmates had progressive levels of access to an array of services, programs, and privileges not found in solitary confinement and which the study researchers correctly acknowledged as being among the limitations that affect generalizability to other settings.[42] In addition, owing to a waiting list of up to three months for admission to the administrative segregation unit, inmates spent time under much more restrictive conditions in disciplinary segregation units while awaiting transfer. Thus, the sequential assessments of psychological functioning may not have been measuring the changes associated with transfer from general population to administrative segregation. Instead, the marked improvement in conditions on movement from disciplinary to administrative segregation, along with progressive increases in privileges after arrival in administrative segregation, could all contribute to the observed improvement in psychological symptoms between the initial and subsequent measures.[43] Other commentators have criticized the study for the exclusion of inmates who were poorly literate or cognitively impaired and are among those most vulnerable to adverse effects of segregation and for an overreliance on inmate self-report without using available clinical data that showed a relatively high incidence of psychiatric crises and suicidality (including 23 episodes of crisis or self-harm and 11 episodes of psychotic symptoms[41]) among the inmates with mental illness in segregation compared with their control group in general population.[44] One of the authors of the Colorado study, while highlighting most of these and other limitations, cautioned that it would be "a mistake" to interpret the study as proof that administrative segregation does not cause harm.[41]

It is hard to imagine any study of the effects of segregation that would be devoid of methodological challenges. Although a thorough analysis of extant literature on the topic is beyond the scope of this editorial, such a review would be likely to leave many readers unsatisfied and many questions unanswered. Nevertheless, there are more than enough empirical data, anecdotal and case reports, individual testimonials, and observations by medical, mental health, and custody staff, including my own observations over several decades, to raise serious concerns about the adverse effects of solitary confinement. We also know that inmates in segregation settings can have suicide rates more than 20 times higher than in general population[45] and the highest rates of self-injurious behaviors,[46] independent of whether the inmate has a mental illness.[47] If we wait for even more compelling evidence before changing current practices, we will continue to expose many individuals to avoidable harm and substantial misery.

American Psychiatry's Stance on Solitary Confinement

The APA has yet to take an unequivocal position opposing prolonged solitary confinement for all inmates. As "the voice and conscience of modern psychiatry,"[48] the APA must issue official position statements that do more than raise concerns solely on behalf of inmates with serious mental illness. In 2012, the APA gave testimony before a subcommittee of the United States Senate Committee on the Judiciary, which was holding hearings given the title, Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences. The only specific recommendation offered by the APA was "that the mental health effects associated with prolonged solitary confinement should be closely considered by the Chairman, Ranking Member, and other members of the Subcommittee, and should influence any future policy made on the practice of solitary confinement in the United States."[49] This suggestion offers little guidance and falls far short of a call for an end to a

practice that the APA testimony acknowledged "may produce harmful psychological effect[s] . . . [that] may include anxiety, anger, cognitive disturbance, perceptual distortion, obsessive thoughts, paranoia, and psychosis."[49] Several months after this testimony, APA approved a position statement that "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided" and calling for "out-of-cell" activities and programs for inmates placed in segregation.[50] Provision of such out-of-cell activities and programs would result in conditions that no longer meet the definition of segregation or solitary confinement used in this article. Thus, taken as a whole, the APA position statement calls for an end to solitary confinement of prisoners with serious mental illness. This is a laudable development, but the APA should extend these principles to all inmates, not just those with serious mental illness.

The most enlightened APA pronouncement regarding segregation appears in the recently released third edition of its correctional psychiatry guidelines. The guidelines in essence call for an end to prolonged segregation, stating that the practice "creates unnecessary and avoidable risks to the health of individual inmates and to the public when those inmates return to the community " (Ref. 51, p 61). The guidelines espouse that the "[i]mprovement in conditions of confinement of long-term segregation [for inmates with serious mental illness] . . . should be extended to all inmates in segregation settings" (Ref. 51, p 63). and that "[c]orrectional systems need to develop alternatives to prolonged segregation for inmates" (Ref. 51, p 66). These guidelines, however, do not represent formal APA policy or position, and thus, they lack the full imprimatur of the organization.

There are reasons worth exploring for the reticence of the APA and many psychiatrists to speak out more forcefully against solitary confinement for inmates who do not have mental illness. Arguments opposed to a more activist stance include observations that not all inmates in segregation show demonstrable harm, and a few even prefer segregation to general-population units. Some correctional psychiatrists also believe that their expertise and authority involve inmates with serious mental illness, and they would overstep their professional bounds if they spoke on behalf of psychologically healthy inmates. A related argument contends that if we broaden our advocacy beyond those inmates with serious mental illness, we will undermine our credibility with correctional authorities. In effect, we need to focus on a battle that we can win and wait for a more politically fertile time to broaden our efforts to all inmates. I will briefly respond to these reservations.

Although some inmates appear to tolerate solitary confinement, we cannot reliably identify who will and who will not suffer measurable harm under those conditions.[17] This uncertainty in no way negates our clinical obligation to oppose the practice.

What about inmates who want to be in solitary confinement? Some inmates prefer living in segregation over general-population units. For many, living in isolation is simply a matter of personal safety. Making prisons safe may not be easy, but it does not require extreme isolation. Solitary confinement is not an appropriate setting for vulnerable inmates or a necessary component of protective custody. Inmates should not have to choose between rape or other assault and complete cloistering. Mental health problems also can lead some inmates to prefer segregation units. When such problems stoke a desire to withdraw, treatment is indicated, not extreme isolation.

Many correctional psychiatrists have expended great effort to achieve even limited success in mitigating segregation conditions for inmates with mental illness. Less progress might have been made if psychiatrists had focused their efforts more broadly. It has been difficult enough to convince courts, let alone correctional officials, to make reforms for seriously ill inmates. Although skirmishes continue, this battle has been won, in most respects. As their practices come under scrutiny, correctional systems inevitably are being compelled to abandon use of extreme isolation for inmates with serious mental illness.

We now need to expand our advocacy to inmates who do not have mental illnesses. Correctional psychiatrists have a responsibility to promote the mental health of all inmates in their facilities, not just those in active treatment. If we do not embrace that responsibility, who will?

An increasing number of prominent health care and other professional organizations have expressed clear opposition to placing inmates in conditions of extreme isolation. Recent examples include the American Academy of Child and Adolescent Psychiatry,[52] the American Bar Association,[53] the American Public Health Association,[54] and the World Medical Association.[55] Criticisms of solitary confinement are also increasingly found in the popular

and scientific press.[56–61] Editorial boards of major newspapers have referred to solitary confinement as "barbarism"[62] and as a practice about which "Americans should be disgusted and outraged" (Ref. 63, p A24). A particularly enlightened corrections commissioner who subjected himself to a stay in segregation wrote about the psychological distress that he experienced after a mere 20 hours.[64] International bodies and blue ribbon commissions that have called for severe restrictions, both in time and conditions, in the use of solitary confinement include the United Nations,[65] the European Committee for the Prevention of Torture,[66] the Inter-American Commission on Human Rights,[67] and the Commission on Safety and Abuse in America's Prisons,[5] to name just a few. Although the APA has yet to take an unequivocal stance opposing solitary confinement for all inmates, I hope and believe that this will change soon.

Conclusion

Solitary confinement, which continues in widespread and excessive use in the United States, poses serious risks to the physical and mental health of all inmates. The arguments for the safety benefits of solitary confinement do not pass muster, the potential for psychological and physiological harm is real, and the misery that can accompany the experience is well known. The APA has led in the effort to restrict solitary confinement for inmates with serious mental illness, but it has not taken the same stance regarding other inmates. It is time for the APA, along with all organizations devoted to mental health, to join the chorus opposed to all draconian practices of prolonged solitary confinement and for correctional systems to listen.

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