Whereas, Correctional facilities, which include prisons and jails, are facilities that house people who have been accused and/or convicted of a crime; and

Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees, people awaiting trial or sentence, or young offenders for short periods of time; and

Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary violations in correctional facilities and detention centers; and

Whereas, Solitary confinement is often used as a punishment for minor nonviolent infractions, such as not standing up for headcount or not returning a food tray; and

Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means of reprisal for reporting unsafe and unsanitary conditions; and

Whereas, Solitary confinement is distinguished from medical isolation and quarantine because solitary confinement is used punitively while medical isolation is used to reduce the spread of infectious disease; and

Whereas, Solitary confinement consists of extended lengths of social separation, sensory deprivation, and the revocation of prison privileges, while medical isolation is a temporary measure overseen by medical professionals who treat prisoners with compassion and provide prisoners resources to aid their recovery; and

Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around 60,000 people, currently reside in some form of solitary confinement; and

Whereas, A year in solitary confinement costs three times as much per prisoner, or an average of $75,000 per prisoner per year; and

Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs; and

Whereas, Chronic social isolation stress, the causes of which include solitary confinement, is associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression, post-traumatic stress disorder, and psychosomatic behavior changes; and
Whereas, There is a strong association between solitary confinement and self-harm; for example, one *JAMA* study found persons held in solitary confinement had a 78% higher suicide rate within the first year after release and another study analyzing over 240,000 incarcerations found that prisoners who experienced solitary confinement accounted for over 50% of self-harm incidents despite accounting for only 7.3% of prison admissions\(^4,13,14\); and

Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an opioid overdose in the first two weeks after release and 24% more likely to die from any cause in the first year after release, even after controlling for potential confounding factors, including substance use and mental health disorders\(^4\); and

Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a higher overall 5-year mortality than those who do not\(^15\); and

Whereas, A United States Department of Justice study indicates that inmates with mental illnesses are more likely to be put in solitary confinement and that solitary confinement further exacerbates their mental illnesses\(^16\); and

Whereas, Solitary confinement increases the likelihood of episodes of psychosis and long-term neurobiological consequences, increasing mentally ill prisoners’ need for psychiatric services\(^12,13\); and

Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of homelessness and unemployment after release, in part due to the lasting psychological stress of confinement\(^17\); and

Whereas, Solitary confinement increases the risk of recidivism, with some studies finding that spending any amount of time in solitary confinement is associated with two times the risk of being reincarcerated within two weeks of release, and other studies finding a 10-25% increased overall risk of recidivism\(^14,18-20\); and

Whereas, Parolees released from solitary confinement commit new crimes in their community 35% more than parolees released from the general prison population, threatening community safety\(^19\); and

Whereas, Transitioning prisoners from solitary confinement to the general prison population prior to release reduces recidivism rates\(^20\); and

Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions, certain racial minorities are disproportionately more likely to be placed in solitary confinement while white prisoners are 14% less likely to be placed in solitary confinement\(^8\); and

Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will be placed in solitary confinement are 80% greater than heterosexual men, and the odds are 190% greater that lesbian and bisexual women will be placed in solitary confinement than heterosexual women\(^21\); and

Whereas, The United Nations and The International Convention on the Rights of the Child prohibit the solitary confinement of anyone under the age of 18\(^22,23\); and
Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the use of solitary confinement for prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures; and

Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than 15 days, because it is a “cruel, inhuman or degrading treatment or punishment”; and

Whereas, The Mandela Rules further state that “solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review”; and

Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical and psychological health issues, and could be considered a cruel and unusual punishment and a human rights violation; and

Whereas, At least some United States correctional facilities have managed to reform and reduce their use of solitary confinement in order to better respect the dignity and human rights of inmates while still maintaining the safety of correctional officers and inmates in jails and prisons; and

Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85% without any other interventions and have seen a concurrent drop in the rate of prisoner on staff violence; and

Whereas, In Mississippi, when correctional facilities reduced their solitary confinement population, violent incidents also dropped by nearly 70%; and

Whereas, A 2015 study found that placing male inmates who were violent in solitary confinement did not effectively deter or alter the probability, timing, or development of future misconduct or violence; and

Whereas, Some correctional facilities have created special units to protect vulnerable groups together with similar access to privileges and programs available to the general population without using solitary confinement as a means of protection; and

Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New York City; and

Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; therefore be it
RESOLVED, That our American Medical Association policy H-430.983, “Reducing the Use of Restrictive Housing in Prisoners with Mental Illness,” be amended by addition and deletion to read as follows:

Reducing Opposing the Use of Restrictive Housing in for Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting oppose the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; and (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities. (Modify Current HOD Policy)

Fiscal Note: Not yet determined

Received: xx/xx/22

REFERENCES:


RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983
Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.
Citation: Res. 412, A-18

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.
Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Citation: Res. 001, A-18

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes
pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22

**Human Rights and Health Professionals H-65.981**
The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.


**Human Rights H-65.997**
Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.


**Appropriate Placement of Transgender Prisoners H-430.982**
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18;