

**Health Impact Review of HB 1312
Concerning solitary confinement
(2021 Legislative Session)**

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Full review

The full Health Impact Review report is available at:

<https://sboh.wa.gov/Portals/7/Doc/HealthImpactReviews/HIR-2021-09-HB1312..pdf>

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Executive Summary
HB 1312, Concerning solitary confinement
(2021 Legislative Session)

Evidence indicates that HB 1312 would likely decrease the use of solitary confinement in DOC state prisons for some people, which would likely decrease reincarceration and improve health outcomes for some people who are incarcerated or who were formerly incarcerated. The impacts of potential alternatives to solitary confinement and the impacts on equity are unclear.

BILL INFORMATION

Sponsors: Peterson, Simmons, Ramel, Ryu, Fitzgibbon, Hackney, Gregerson, Santos, Senn, Ortiz-Self, Dolan, Davis, Valdez, Bateman, Johnson, J., Ormsby, Bergquist, Morgan, Lekanoff, Frame, Harris-Talley, Leavitt, Pollet, Callan, Macri

Summary of Bill:

- Restricts the use of solitary confinement* in Washington State Department of Corrections (DOC) state prisons, except in limited circumstances.
- Requires the Secretary of DOC to adopt certain regulations, policies, and procedures.
- Directs cities and counties that operate jails to compile specific information on the use of solitary confinement at each jail and to submit information to the Washington Association of Sheriffs and Police Chiefs (WASPC). Requires WASPC to submit reports to the Legislature.

HEALTH IMPACT REVIEW

Summary of Findings:

This Health Impact Review found the following evidence for relevant provisions in HB 1312:

Pathway 1: Restrictions to solitary confinement

- **Informed assumption** that restricting the use of solitary confinement in DOC state prisons, except in limited circumstances, would decrease the use of solitary confinement for some people who are incarcerated. This informed assumption is based on past and current DOC reform efforts, bill provisions, and information from key informants.
- **Strong evidence** that decreased use of solitary confinement would improve health outcomes for some people who are incarcerated or were formerly incarcerated.
- **Strong evidence** that decreased use of solitary confinement would decrease reincarceration.
- **Very strong evidence** that decreased reincarceration would improve health outcomes.

* Prison systems use various terms to refer to segregation (restricted/restrictive housing; administrative segregation; disciplinary segregation; maximum custody; supermax; protective custody; special housing units; security housing units; special management units; intensive management; etc.); solitary confinement is typically used as an umbrella term to refer to all forms of segregation.^{2,3} This report uses the term solitary confinement to refer to all forms of segregation in alignment with language in HB 1312, the published literature, and recommendations from key informants, unless discussing specific DOC housing types or policies.

Pathway 2: Alternatives to solitary confinement

- **Informed assumption** that requiring DOC to undertake rulemaking to establish alternatives to solitary confinement would result in DOC undertaking rulemaking and developing and implementing such alternatives. This informed assumption is based on information from key informants representing DOC.
- **Informed assumption** that DOC undertaking rulemaking and developing and implementing alternatives to solitary confinement would result in some number of people experiencing such alternatives while incarcerated. This informed assumption is based on information from key informants.
- **Unclear evidence** of how potential alternatives to solitary confinement would impact conditions of confinement for people who are incarcerated and DOC staff, since restrictions to solitary confinement may be implemented before alternatives to solitary confinement are in place, and since conditions of and effects of alternative interventions compared to those of solitary confinement are unknown.
- **Unclear evidence** of how improved health outcomes would impact health equity for people who are incarcerated or were formerly incarcerated due to limited research on how restricting solitary confinement may impact different groups; the intersectionality of overlapping identities; current inequities due to racism in the criminal legal system; and continued opportunities for people to be held in solitary confinement.

Introduction and Methods

A Health Impact Review is an analysis of how a proposed legislative or budgetary change will likely impact health and health disparities in Washington State ([RCW 43.20.285](#)). For the purpose of this review ‘health disparities’ have been defined as the differences in disease, death, and other adverse health conditions that exist between populations ([RCW 43.20.270](#)). Differences in health conditions are not intrinsic to a population; rather, inequities are related to social determinants (e.g., access to healthcare, economic stability, racism). This document provides summaries of the evidence analyzed by State Board of Health staff during the Health Impact Review of House Bill 1312 ([HB 1312](#)).

Staff analyzed the content of HB 1312 and created a logic model depicting possible pathways leading from the provisions of the bill to health outcomes. We consulted with experts and contacted key informants about the provisions and potential impacts of the bill. We conducted an objective review of published literature for each pathway using databases including PubMed, Google Scholar, and University of Washington Libraries. We evaluated evidence using set criteria and determined a strength-of-evidence for each step in the pathway.

Staff also completed key informant interviews to gather additional supporting evidence. In total, we spoke with 37 key informant interviewees, including: 11 DOC staff members (e.g., leadership, unit managers, correctional officers, mental health professionals); 11 staff members from other state departments of corrections (i.e., North Dakota and Oregon); 7 staff members from the Office of the Corrections Ombuds (OCO); 4 researchers who have previously or are currently working with DOC to restrict the use of solitary confinement; 3 individuals representing community-based organizations; and 1 researcher familiar with national actions related to solitary confinement. More information about key informants and detailed methods are available upon request.

The following pages provide a detailed analysis of the bill including the logic model, summaries of evidence, and annotated references. The logic model is presented both in text and through a flowchart (Figure 1). The logic model includes information on the strength-of-evidence for each relationship. The strength-of-evidence has been established using set criteria and summarized as:

- **Very strong evidence:** There is a very large body of robust, published evidence and some qualitative primary research with all or almost all evidence supporting the association. There is consensus between all data sources and types, indicating that the premise is well accepted by the scientific community.
- **Strong evidence:** There is a large body of published evidence and some qualitative primary research with the majority of evidence supporting the association, though some sources may have less robust study design or execution. There is consensus between data sources and types.
- **A fair amount of evidence:** There is some published evidence and some qualitative primary research with the majority of evidence supporting the association. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.

- **Expert opinion:** There is limited or no published evidence; however, rigorous qualitative primary research is available supporting the association, with an attempt to include viewpoints from multiple types of informants. There is consensus among the majority of informants.
- **Informed assumption:** There is limited or no published evidence; however, some qualitative primary research is available. Rigorous qualitative primary research was not possible due to time or other constraints. There is consensus among the majority of informants.
- **No association:** There is some published evidence and some qualitative primary research with the majority of evidence supporting no association or no relationship. The body of evidence may include sources with less robust design and execution and there may be some level of disagreement between data sources and types.
- **Not well researched:** There is limited or no published evidence and limited or no qualitative primary research and the body of evidence has inconsistent or mixed findings, with some supporting the association, some disagreeing, and some finding no connection. There is a lack of consensus between data sources and types.
- **Unclear:** There is a lack of consensus between data sources and types, and the directionality of the association is ambiguous due to potential unintended consequences or other variables.

This review was subject to time constraints, which influenced the scope of work for this review. The annotated references are only a representation of the evidence and provide examples of current research. In some cases, only a few review articles or meta-analyses are referenced. One article may cite or provide analysis of dozens of other articles. Therefore, the number of references included in the bibliography does not necessarily reflect the strength-of-evidence. In addition, some articles provide evidence for more than one research question, so are referenced multiple times.

Analysis of HB 1312 and the Scientific Evidence

Summary of relevant background information

- All U.S. prison systems have a mechanism for separating some people who are incarcerated from the general prison population.¹
- Nationally, “prison systems across the [U.S.] separate some [people who are incarcerated] from the general [prison] population and put them into special housing units, typically with more isolating conditions. The reasons for doing so include the imposition of punishment (“disciplinary segregation”), protection (“protective custody”), and incapacitation (often termed “administrative segregation”).”²
- Prison systems use various terms to refer to segregation (restricted/restrictive housing; administrative segregation; disciplinary segregation; maximum custody; supermax; protective custody; special housing units; security housing units; special management units; intensive management; etc.); solitary confinement is typically used as an umbrella term to refer to all forms of segregation.^{2,3}
- While policies, practices, and conditions of solitary confinement vary across prison systems,³ the 2015 United Nations Standard Minimum Rules for the Treatment of Prisoners, known as the Nelson Mandela Rules, defined solitary confinement as “confinement of [people] for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement of a time period in excess of 15 consecutive days.”⁴
- Key informants described the conditions of solitary confinement in Washington State prisons in multiple ways. Conditions of solitary confinement vary by unit and facility and may include: People locked in a cell with no or limited access to external stimuli (e.g., reading materials, television, radio, phone, telecommunications, mirrors, clocks, visitors, other people, commissary) and limited time out of their cells for showers or to go to the yard (which may or may not be open to the outside). People restrained at the wrists and ankles and accompanied by two guards when they leave their cell. People experiencing sensory deprivation; constant illumination or very dark environments; other people screaming, yelling, crying, or throwing feces; idleness and lack of physical activity; and restricted movement. Key informants that have visited or worked in solitary confinement units stated that “you feel a physical and mental response” when you enter solitary confinement units, the energy feels negative, and “you literally leave with a headache” (personal communication, May-July 2021). DOC staff have stated that they feel on edge all the time and that interactions can be unpredictable and violent (personal communication, DOC, July 2021).
- During the 2020 Legislative Session, the Washington State Legislature passed HB 2277, Concerning youth solitary confinement ([Chapter 333, 2020 Laws](#)), which prohibits the use of solitary confinement in juvenile facilities and institutions.
- In April 2021, the Governor appointed a new secretary of Washington State Department of Corrections (DOC) effective May 2021.⁵

- DOC operates 12 state prisons with custody levels ranging from minimum to maximum security.⁶ DOC uses two forms of restrictive housing: Administrative Segregation and Maximum Custody.
 - Administrative Segregation (Ad Seg) is used to “temporarily remove [a person who is incarcerated] from the general population until a timely and informed decision can be made about appropriate housing based on their behavior.”⁷ Ad Seg may be used if a person poses a threat to staff or others; requests protection; is being transferred to a more secure facility; poses a risk of escape; or is under investigation for a threatening behavior.⁷
 - Maximum Custody (MAX Custody) is the most restrictive form of housing, and “individuals can be placed in MAX Custody when they pose a significant risk to the safety and security of employees, contract staff, volunteers or other individuals, [or] have validated protection needs.”⁷ People placed in MAX Custody with serious mental illness may be placed in a specialized MAX Custody Intensive Treatment Unit (personal communication, DOC, June 2021). People may be held in MAX Custody “for an indeterminate period, usually following one or more rule violations, with return to the general prison population contingent on meeting specific benchmarks.”⁸
- Of the 12 DOC state prisons, eight major facilities may house people in Ad Seg or MAX Custody in either designated cells or in separate units or buildings depending on the infrastructure of the prison,⁷ and four minor facilities may house people in Ad Seg for a maximum of 14 days (personal communication, DOC, August 2021). Five DOC state prisons have separate units or buildings, referred to as Intensive Management Units (IMUs). IMUs are “an all-male unit or building, housing people in solitary confinement [i.e., both Ad Seg and MAX Custody] (with highly restricted access to commissary, phones, radios, televisions, visitors, and roughly 10 hours per week out-of-cell) for durations ranging from months to years.”⁸
- [WAC 137-32-030](#) outlines conditions of confinement for people held in Ad Seg or MAX Custody, including conditions related to adequate lighting and ventilation; meals; personal hygiene; communication; reading material; legal representation; recreation; access to healthcare services; and access to other programming.⁹ The WAC is open (as of July 2021) for rulemaking and is expected to be finalized in August 2021 (personal communication, DOC, July 2021).¹⁰
- [DOC Policy 320.255](#) and the DOC Restrictive Housing Level System Grid outline minimum privileges in Ad Seg and MAX Custody to include: “Showers, ten minutes, three times a week; recreation one hour a day, five times a week[...]; limited telephone access; 1st class mail; at least two books or other publications; ten personal photos; and up to \$10 weekly commissary order for personal hygiene and correspondence materials.”¹¹ The Restrictive Housing Level System Grid details eligibility for additional privileges (e.g., radio, television, publications, additional value in commissary items) while a person is held in solitary confinement.¹² For example, 30 days after placement in restrictive housing (i.e., Level 2) a person is eligible for a radio, dependent on behavior.

After 60 days in restrictive housing (i.e., Level 3), dependent on behavior, they are eligible for either one radio or one television.

- Due to the ongoing impacts of the 2019 Coronavirus (COVID-19) pandemic, DOC has implemented Restrictive Housing Units Policy Exceptions. Effective February 9, 2021, people held in Ad Seg receive “a radio immediately after the initial review occurs, pending no concerns by the Facility Risk Management Team.”¹³ Concerns that would prevent someone from receiving a radio include “violence outside of an average one-on-one fight or introduction of contraband,” in which case the person would need to earn access to a radio based on behavior during their first 30 days on the unit.¹³ In units with television capability, those who receive immediate access to a radio are eligible for a television 30 days after placement, based on behavior.¹³ Other adjustments include allowing people held in restrictive housing access to 20 personal photos and an increased cap on commissary spending.¹³
- In 2011 and 2019, DOC partnered with the Vera Institute of Justice (Vera) to reduce the use of solitary confinement in DOC state prisons and to find safer and more effective alternatives. The goals of the partnership included eliminating the use of solitary confinement for vulnerable adults, especially those with serious mental illness, improving living conditions, and reducing the length of time people spend in solitary confinement.^{14,15}
 - From February 2019 through December 2020, DOC and Vera partnered on the “Safe Prisons, Safe Communities: From Isolation to Dignity and Wellness Behind Bars” initiative.¹⁴ As a result, DOC implemented updated restrictive housing policies (effective March 2020).¹⁴ The new policies narrowed the reasons people can be placed in solitary confinement and expanded access to visitation for those held in either Ad Seg or MAX Custody.¹⁴ DOC also reduced the maximum time limit a person can be held in Ad Seg from 47 days to 30 days.¹⁴ Additionally, DOC developed plans and prepared to repurpose several restrictive housing units into specialized, non-restrictive types of housing, and provided training for staff working in these settings.¹⁴ Over the course of the project (baseline 12/31/2018 to 9/30/2020) data show:¹⁴
 - A 3.3% decrease in the total number of people in restrictive housing;
 - A 33% decrease in the median length of stay in MAX Custody;
 - A 57% reduction in serious staff assaults in restrictive housing; and
 - A 45% reduction in self-harm/suicide attempts in restrictive housing.^{14,15}
- In 2016, University of California, Irvine began a four-year collaboration with DOC to examine their use of restrictive housing. Researchers reviewed 15 years of administrative data, completed written surveys and conducted interviews with people held in restrictive housing and staff working in IMUs.¹⁶ They found that DOC has made improvements and “implemented an array of reforms in pursuit of three goals: (1) reducing the number of people in restrictive housing, (2) reducing the length of time individuals spend in restrictive housing, and (3) mitigating the harms of the harsh conditions of restrictive housing.”¹⁶ Reform efforts included changes to conditions of confinement (e.g.,

additional congregate opportunities; new programmatic offerings); organizational changes (e.g., creation of Mission Housing Administrator leadership position; development of Facility Risk Management Teams); behavior modification programming (e.g., offering in-cell Cognitive Behavioral Therapy; creation of transition units); mental health programming (e.g., elimination of self-harm infractions; increased access to counselors); and preventive reforms (e.g., use of alternative sanctions and alternative specialized housing units).¹⁶

- In response to COVID-19, DOC policy required that people with COVID-19 symptoms be separated from the general population in quarantine/medical isolation. This resulted in people experiencing quarantine in their cells or being moved to medical isolation units (personal communication, DOC, May 2021). Additionally, unit-wide or facility-wide lockdowns were also used for quarantine (personal communication, DOC, May 2021). DOC stated that use of restrictive housing has not increased as a result of the COVID-19 pandemic⁷ and “even with COVID-19 response actions in place, DOC continues to reduce its use of restrictive housing to address...disciplinary issues, where appropriate.”¹⁷
- In 2011, the United Nations Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment stated that, in certain circumstances, solitary confinement may constitute an act of torture.¹⁸ On February 28, 2020, the Special Rapporteur repeated concerns about the excessive use of solitary confinement in the U.S.¹⁹ The Special Rapporteur stated, “the severe and often irreparable psychological and physical consequences of solitary confinement and social exclusion are well documented and can range from progressively severe forms of anxiety, stress, and depression to cognitive impairment and suicidal tendencies. This deliberate infliction of severe mental pain or suffering may well amount to psychological torture.”¹⁹
- In 2013, the American Public Health Association declared solitary confinement a public health issue and authored a number of recommendations for federal, state, and local correctional authorities to restrict the use of solitary confinement to improve the health of people who are incarcerated.¹⁸
- In 2015, the President directed the U.S. Attorney General to review the use of solitary confinement in federal prisons. As a result, the U.S. Department of Justice (DOJ) issued a number of recommendations for federal prison system reform, including: 1) restricting the use of solitary confinement for people who are pregnant, LGBTI people, and people with serious mental illness; 2) reducing the amount of time people spend in solitary confinement; 3) using the least restrictive housing options needed to ensure the safety of individuals, staff, and the general prison population; 4) outlining a clear plan to return someone to the general prison population as quickly as possible; and 5) ensuring people held in solitary confinement receive regular health (including mental health) evaluations.² On March 1, 2016, a presidential memorandum (“Limiting the Use of Restrictive Housing by the Federal Government”) directed executive departments and agencies to implement DOJ’s recommendations.²
- In 2016, the American Correctional Association, which publishes accreditation standards for prisons in the U.S., issued new standards related to solitary confinement which restricted the use of solitary confinement based on gender identity alone as well as for

people who are pregnant, persons under 18 years of age, and people with serious mental illness.² The revised standards also included increased oversight for solitary confinement (e.g., training for staff working with people held in solitary confinement).²

- Since 2014, 12 states have enacted legislation that in some way restricts the use of solitary confinement in adult state prison systems (e.g., restricting entry criteria by demographics or population group [e.g., pregnancy or postpartum status]; limiting length of time a person may consecutively or cumulatively be held in solitary confinement; clarifying the definition of or general intent of segregation to restrict use; requiring medical examinations for placement) (unpublished data, National Conference of State Legislatures [NCSL], June 2021). Two states (Colorado and New York State) have enacted legislation creating specific alternatives to solitary confinement (unpublished data, NCSL, June 2021). In 2014, Colorado enacted legislation creating a step-down unit and requiring alternative housing for people with serious mental illness (unpublished data, NCSL, June 2021). In 2021, New York State passed [Senate Bill S2836](#) restricting solitary confinement and creating alternative options (i.e., establishing residential rehabilitative confinement options with increased unrestrained out-of-cell time, interaction in congregate settings, and access to work and educational opportunities).²⁰

Summary of HB 1312

- Defines solitary confinement[†] as confinement of a person who is incarcerated in a correctional facility, pursuant to disciplinary, administrative, protective, investigative, mental health or medical, or other classification, in a cell or similarly confined holding or living space, alone or with others, for 20 hours or more per day.
 - States that a person shall not be placed in solitary confinement for more than 15 consecutive days and for no more than 45 cumulative days during a single fiscal year.
- Restricts the use of solitary confinement in DOC state prisons, except in limited circumstances.
 - States that a person who is incarcerated may not be placed in solitary confinement unless there is a reasonable cause (e.g., threats, conduct) to believe that they would pose a substantial risk of immediate serious harm to themselves or someone else and a less restrictive intervention would be insufficient to reduce the risk.
 - Prohibits the use of solitary confinement for non-disciplinary reasons.
 - States that a person may not be placed in solitary confinement pending investigation of a disciplinary offense unless the person poses a serious and imminent danger to themselves, staff, others in the general population, or the public (e.g., violence, escape). Stipulates a person pending investigation of a disciplinary offense must be considered for release to the general prison population every 24 hours and may not be held for more than 15 consecutive days.

[†] Prison systems use various terms to refer to segregation (restricted/restrictive housing; administrative segregation; disciplinary segregation; maximum custody; supermax; protective custody; special housing units; security housing units; special management units; intensive management; etc.); solitary confinement is typically used as an umbrella term to refer to all forms of segregation.^{2,3} This report uses the term solitary confinement to refer to all forms of segregation in alignment with language in HB 1312, the published literature, and recommendations from key informants, unless discussing specific DOC housing types or policies.

- Prohibits a person from being held in solitary confinement on the basis of race, creed, color, national origin, nationality, ancestry, age, marital status, domestic partnership or civil union status, affectional or sexual orientation, genetic information, pregnancy or breastfeeding status, sex, gender identity or expression, disability, or atypical hereditary cellular or blood trait.
- Prohibits a person who is a member of a vulnerable population from being placed in solitary confinement. Specifies that a member of a vulnerable population who would otherwise be placed in solitary confinement must be screened for placement in an alternative unit (e.g., residential treatment unit, close observation unit, medical unit).
 - Defines vulnerable population as any person who is incarcerated and:
 - Is 25 years of age or younger;
 - Is 60 years of age or older;
 - Has a mental disorder, as defined by [RCW 71.05.020](#), or where there is evidence of a diagnosis of a serious mental illness, a history of psychiatric hospitalization, or a history of disruptive or self-injurious behavior including, but not limited to, serious and/or repeated self-harm that may be the result of a mental disorder or condition;
 - Has a developmental disability, as defined in [RCW 71A.10.020](#);
 - Has a serious medical condition that cannot effectively be treated in solitary confinement;
 - Is pregnant, postpartum, or has recently experienced miscarriage or terminated a pregnancy;
 - Has a physical disability that cannot be accommodated in solitary confinement; or
 - Has a significant auditory or visual impairment.
- Specifies that solitary confinement may be permitted in cases of:
 - A facility-wide or unit-wide lockdown that is required to ensure the safety of people who are incarcerated and staff or due to quarantine or isolation measures undertaken in response to a public health crisis or declared state of emergency;
 - Emergency confinement;
 - Medical isolation (including for reasons of mental health emergencies) in a residential treatment unit, close observation unit, or medical unit; and
 - Voluntary or non-voluntary protective custody.
- Requires that a person receive a personal, comprehensive medical and mental health exam by a qualified medical provider prior to being placed in solitary confinement unless advance evaluation would create a substantial threat to security or safety. Requires a daily physical and mental health examination to determine if someone is a member of a vulnerable population.
- Specifies a person who is incarcerated must have timely, fair, and meaningful opportunities to contest the confinement, including a right to an initial hearing within 72 hours of placement in solitary confinement.

- Specifies certain conditions for solitary confinement, including conditions related to environment (e.g., ventilation, lighting, temperature, sanitation); time outside of cell; access to programming (e.g., recreation, education, therapies, activities, social interaction); access to food, water, and other basic necessities; and access to healthcare services.
- Prohibits a person from being released directly from solitary confinement to the community.
- Requires the Secretary of DOC to adopt certain regulations, policies, and procedures, including:
 - Plans for providing step-down and transitional units, programs, and staffing for people held in solitary confinement;
 - Regulations establishing less restrictive interventions to solitary confinement; and
 - Trainings for staff working with people held in solitary confinement.
- Directs cities and counties that operate jails to compile specific information on the use of solitary confinement at each jail and to submit information to the Washington Association of Sheriffs and Police Chiefs (WASPC). Requires WASPC to submit an initial and updated report to the Legislature.

Health impact of HB 1312

Evidence indicates that HB 1312 would likely decrease the use of solitary confinement in DOC state prisons for some people, which would likely decrease reincarceration and improve health outcomes for some people who are incarcerated or who were formerly incarcerated. The impacts of potential alternatives to solitary confinement and the impacts on equity are unclear.

Pathway to health impacts

The potential pathways leading from the provisions of HB 1312 to decreased health inequities are depicted in Figure 1. This review made the informed assumption that restricting the use of solitary confinement in DOC state prisons would likely decrease the number of people who are currently held or could potentially be held in solitary confinement and decrease the amount of time people are held in solitary confinement for some number of people who are incarcerated. This informed assumption is based on past and current DOC reform efforts, bill provisions, and information from key informants. There is strong evidence and it is well-accepted by the scientific community that people who are held in solitary confinement have worse health outcomes while incarcerated and after release to community.^{3,8,18,21-24} There is strong evidence that decreased use of solitary confinement would decrease reincarceration,^{1,25-27} which would also improve health outcomes.²⁸⁻³⁴

This review also made the informed assumptions that requiring DOC to undertake rulemaking to establish alternatives to solitary confinement would result in DOC undertaking rulemaking and developing and implementing such alternatives, which would result in some number of people experiencing such alternatives while incarcerated. These informed assumptions are based on information from key informants. There is unclear evidence of how potential alternatives to solitary confinement would impact conditions of confinement for people who are incarcerated and DOC staff since restrictions to solitary confinement may be implemented before alternatives to solitary confinement are in place, and since conditions of and effects of alternative interventions compared to those of solitary confinement are unknown.

Lastly, there is unclear evidence of the bill’s impact on equity due to limited research on how restricting solitary confinement may impact different groups; the intersectionality of overlapping identities; current inequities due to racism in the criminal legal system; and continued opportunities for people to be held in solitary confinement. Therefore, it is unclear how restricting the use of solitary confinement may impact equity for people who are incarcerated or were formerly incarcerated.

Scope

Due to time limitations, we only researched the most direct connections between provisions of the bill and health inequities and did not explore the evidence for all possible pathways. For example, we did not evaluate potential impacts related to:

- City and county jails. HB 1312 requires cities and counties that operate jails to compile specific information on the use of solitary confinement at each jail and to submit information to the Washington Association of Sheriffs and Police Chiefs (WASPC). Researchers have noted that, nationally, “...information on county jails is important to underscore because counties were responsible, as of 2016, for 91% of the jails in the [U.S.], and ‘11.4 million individuals pass through jail each year.’”² Provisions of the bill may impact the operations of city and county jails, which could impact people who are held in these facilities in Washington State.
- Effects on families and communities of people who are held in solitary confinement. Family members of people currently or previously held in solitary confinement testified before the Washington State Senate Human Services, Reentry & Rehabilitation Committee to the negative effects they experienced as a result of their loved ones being held in solitary confinement.³⁵ Additionally, advocates for restricting the use of solitary confinement highlighted that the practice does not prepare people to successfully return to their communities.³⁵
- Future generations. Research has shown that parental incarceration can impact children’s mental, emotional, and social health.^{33,36} For example, “[B]lack youths’ perceptions of law enforcement are shaped by the vicarious and collective experiences of their friends and family members”³⁷ and “[g]iven the frequent and disproportionate arrest of [B]lack Americans, it is hard to find a [B]lack child who does not have a friend or relative who has not been arrested or ‘known to police.’”³⁷

Magnitude of impact

HB 1312 (deemed the Solitary Confinement Restriction Act) would restrict the use of solitary confinement, except in limited circumstances, for all people who are incarcerated at DOC’s 12 state prisons. The provisions of the bill would impact all people who are incarcerated at DOC state prisons, as everyone who is incarcerated has the potential to be placed in solitary confinement. The provisions of the bill would not apply to people who are incarcerated in jails, juvenile facilities and institutions, immigration or military detention facilities, or other federal facilities in the state. Additionally, the provisions would not apply to individuals who are held in the Special Commitment Center, a total confinement facility for persons convicted of violent sexual offenses and operated by the Department of Social and Health Services on McNeil Island.³⁸ Therefore, while HB 1312 would apply to all people who are incarcerated in DOC state

prisons, it would not impact all individuals who are incarcerated or who are held in solitary confinement in Washington State.

Researchers have noted that it is difficult to estimate the number of people who are held in solitary confinement due to differences in definitions, policies, procedures, and conditions across jurisdictions.^{2,3,18} National surveys with the directors of prison systems with the Federal Bureau of Prisons, 45 states, the District of Columbia, and the U.S. Virgin Islands (representing 96.4% of the total U.S. prison population) estimated that in 2014, “some 80,000-100,000 people were...in restricted housing (however termed) in U.S. prisons—or one in every six or seven prisoners” not including people incarcerated in jails, juvenile facilities and institutions, or immigration and military detention.² Key informants representing researchers studying the use of and effects of solitary confinement explained that available data generally represent a point in time count of those held in solitary confinement (personal communication, June 2021). However, an estimated 25% to 33% of the total prison population have been held in solitary confinement at some point during their incarceration (personal communication, June 2021). In 2014 (the most current data available), the median percentage of the U.S. prison population held in solitary confinement 22 hours or more per day, for 15 consecutive days or longer was 5.1%.² Approximately 17.7% of these individuals had been in solitary confinement for 15 days to one month; 28.9% for one to three months; 16.4% for three to six months; 13.0% for 6 months to one year; 13.1% for one to three years; 5.5% for three to six years; and 5.4% for 6 years or more.²

Various studies have estimated the number of people held in solitary confinement in Washington State. The 2014 survey found that 1.7% (274 individuals) of Washington State’s prison population was held in solitary confinement for 22 hours or more per day, for 15 consecutive days or longer.² At the time of the survey, approximately 5.8% (16) of these individuals had been in solitary confinement for 15 days to one month; 20.1% (55) for one to three months; 24.8% (68) for three to six months; 25.5% (70) for 6 months to one year; 13.5% (37) for one to three years; 5.8% (16) for three to six years; and 4.4% (12) for six years or more.² Across 40 jurisdictions that provided data regarding female prisoners, “the jurisdiction reporting the lowest percentage was Washington [State], where approximately 0.1% of the female custodial population (1 out of 1,136) was in [solitary confinement].”² Key informants confirmed that solitary confinement is not typically used at the women’s prison in Washington State (personal communications, May 2021).

The University of California, Irvine analyzed DOC administrative data from 2002 through 2017 to examine patterns in the use of solitary confinement over time.¹⁶ They found that, “the number of people held in [MAX Custody] across the state has fluctuated from a low of 149 (in 2002) to a peak of 472 (in 2011). By 2014, [DOC] reforms had cut this peak population nearly in half, to 283. But the population increased again, by more than 20[%] over the next three years, rising back to 342 in 2017.”¹⁶ Researchers found that the mean time spent in MAX Custody has steadily declined since 2011.¹⁶ However, the proportion of people held in IMUs and the cumulative time spent in solitary confinement has increased.¹⁶ In 2017, approximately 34% of Washington’s general prison population had been held in an IMU.¹⁶

On July 31, 2021, a total of 13,788 people were incarcerated in the 12 DOC state prisons.³⁹ On that date, DOC reported that 497 people were held in Ad Seg and 219 people were held in MAX

Custody.³⁹ DOC and Vera reported an overall decrease of 3.3% of individuals held in solitary confinement in September 2020 compared to December 31, 2018.¹⁴ The average length of time held in Ad Seg was 28.8 days and the median time held was 16 days, which “indicates that while many people spend less than the 30-day limit in [Ad Seg] some remain there for longer periods of time, with a very small number of outlier cases where people are kept in [Ad Seg] for years.”^{14,40} The average length of time held in MAX Custody was 348 days, and the median time held was 133 days.^{14,15} In August 2021, DOC reported a roughly 20% decrease in weekly average daily population (ADP) in MAX Custody in the first half of 2021.³⁹

On January 7, 2021, the Office of the Corrections Ombuds (OCO) opened an investigation regarding a complaint from a person incarcerated at Monroe Correctional Complex (MCC) who had been held in solitary confinement since November 3, 2020.¹¹ While DOC policy [320.200](#) states that individuals will be housed in Ad Seg for a maximum of 30 days regardless of the placement designation, OCO found the person was housed in Ad Seg for 112 days.¹¹ These findings prompted OCO to request additional data regarding persons held in Ad Seg at MCC. The subsequent review of DOC data showed “one individual spent 104 days in solitary confinement for yelling and throwing debris from his cell during a disturbance; one individual spent 92 days in solitary confinement for altering his [JPay player[‡]]; one individual spent 56 days in solitary confinement under suspicion of involvement in a disturbance before being found to not have been involved at all; [and] one individual spent 256 days in solitary confinement for attempting to receive contraband via mail.”¹¹

Overall, HB 1312 has the potential to impact all people who are incarcerated at the 12 DOC state prisons, including those who are currently held or could potentially be held in solitary confinement.

[‡] JPay is a private company DOC contracts with to provide money transfer and electronic media services for people who are incarcerated in state prisons and their family and friends.

Logic Model

Pathway 1: Restrictions to solitary confinement

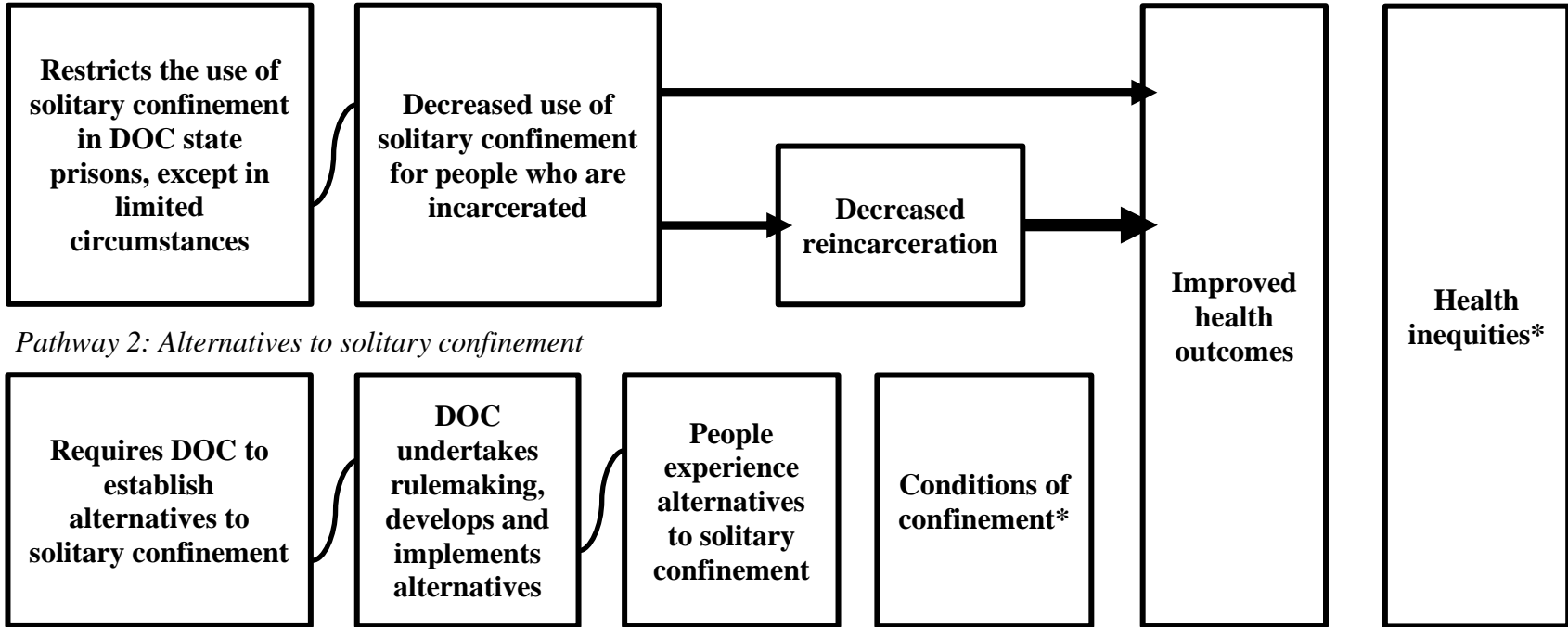
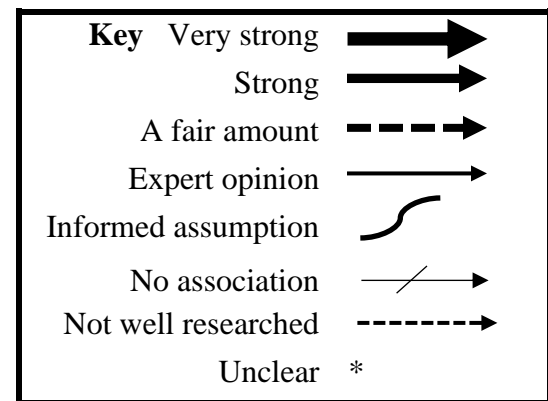


Figure 1:
Concerning solitary confinement
HB 1312



Summaries of Findings

Pathway 1: Restrictions to solitary confinement

Would restricting the use of solitary confinement in Washington State Department of Corrections state prisons, except in limited circumstances, decrease the use of solitary confinement for people who are incarcerated?

We made the informed assumption that restricting the use of solitary confinement in Washington State Department of Corrections (DOC) state prisons would likely decrease the number of people who are currently held or could potentially be held in solitary confinement as well as decrease the amount of time people are held in solitary confinement for some number of people who are incarcerated. This informed assumption is based on past and current DOC reform efforts, bill provisions, and information from key informants.

Since the early 2000s, DOC has been working to reduce the use of solitary confinement at state prisons and to shift staff culture related to solitary confinement (personal communications, May-June 2021).¹⁶ Evidence from sustained past and current reform efforts suggests that DOC is likely to continue to implement existing and future efforts to restrict the use of solitary confinement and improve conditions. Researchers from University of California, Irvine noted that, “DOC is a leader among state correctional systems in restrictive housing reform; administrative leaders have built a solid foundation for continued reforms—including [Intensive Management Unit (IMU)] population reductions, decreases in IMU sentences, and improvements in conditions.”¹⁶

In 2011 and 2019, DOC partnered with the Vera Institute of Justice (Vera) to reduce the use of solitary confinement in DOC state prisons and to find safer and more effective alternatives. The goals of the partnership included eliminating the use of solitary confinement for vulnerable adults, especially those with serious mental illness, improving living conditions, and reducing the length of time people spend in solitary confinement.^{14,15} Evidence from Vera and from University of California, Irvine suggests that DOC has made progress in meeting these goals. For example, from 12/31/2018 to 9/30/2020, DOC data show a 3.3% decrease in the total number of people in restrictive housing; a 33% decrease in the median length of stay in Maximum Custody (MAX Custody); a 57% reduction in serious staff assaults in restrictive housing; and a 45% reduction in self-harm/suicide attempts in restrictive housing.^{14,15}

Moreover, researchers from University of California, Irvine examined 15 years of DOC administrative data and found that, as part of efforts to shift staff culture, people held in solitary confinement were “in the IMU for specific, identifiable reasons; prisoners receive regular, individualized assessments regarding their continued IMU placement by a classification committee; and treatment and custody staff work together to develop targeted interventions with the goal of transitioning even the most behaviorally challenging and risky individuals out of the IMU. This is in stark contrast to other [state prison] systems...”¹⁶ As part of this work, DOC has implemented reforms establishing transition and transfer pods and other alternative units. For example, DOC has a Special Offenders Unit (SOU), for those in MAX Custody with serious mental illness, where people receive more intensive mental health treatment.¹⁴ In addition, DOC “has been and plans to continue ‘repurposing’ [IMUs] for other less restrictive...units for gang

dropouts, transition units for people moving between IMU and general population, and a potential unit for people with traumatic brain injuries.”¹⁶ DOC also has a workplan of restrictive housing initiatives that the agency is planning, developing, and implementing for 2021 and 2022.¹⁰ In July 2021, DOC opened transfer pods in IMUs at three state prisons (i.e., Monroe Corrections Center, Stafford Creek Corrections Center, and Washington Corrections Center).¹⁰

Since DOC has made and is currently working on reforms to restrict the use of solitary confinement, we have made the assumption that DOC will likely continue to work to decrease the number of people held in solitary confinement and to decrease the amount of time people are held in solitary confinement.

Number of people held in solitary confinement

A joint report and survey with state prison systems conducted by the Association of State Correctional Administrators and Yale Law School found that, “correctional policies made getting into segregation relatively easy, and few systems focused on getting people out. The criteria for entry were broad.”² Therefore, evidence suggests that restricting entry into solitary confinement may reduce the number of people who are currently held or could potentially be held in solitary confinement.

If passed, HB 1312 would restrict the entry criteria for people to be placed in solitary confinement, which could decrease the number of people who could potentially be held in solitary confinement. Provisions of the bill prohibit the use of solitary confinement for non-disciplinary reasons; on the basis of certain demographic characteristics alone (e.g., race, age, gender identity, disability status); and for members of a vulnerable population. The bill defines vulnerable population to include people age 25 years or younger; age 60 years or older; with a mental disorder (defined by RCW 71.05.020) or exhibiting a history of behavior that may be the result of a mental health disorder or condition; with a developmental disability (defined by RCW 71A.10.020); with a serious medical condition that cannot be effectively treated in solitary confinement; who are pregnant, postpartum, or have recently suffered a miscarriage or terminated a pregnancy; with needs related to a physical disability that cannot be accommodated in solitary confinement; or with a significant auditory or visual impairment. Though not specified in bill provisions, this would likely require DOC to develop and use a screening tool to determine if a person is a member of a vulnerable population.

While there is some evidence to suggest that screening may not accurately identify members of vulnerable populations (see Pathway 2 for further discussion),¹⁶ key informants who work in DOC IMU settings stated that they currently work with people held in solitary confinement who could be identified as a member of a vulnerable population as defined in HB 1312 (personal communications, DOC, June 2021). DOC staff anticipated that restrictions outlined in HB 1312 would likely decrease their caseload and the number of people currently held in solitary confinement (personal communications, DOC, June 2021).

Furthermore, provisions of HB 1312 would require people be evaluated for removal from solitary confinement, placement in an alternative housing unit, and/or return to the general prison population every 24 hours. Section 4(1)(e) of the bill would require a medical provider to conduct a daily mental health and physical health examination for each person held in solitary

confinement to determine whether they are a member of a vulnerable population. The bill would require that those identified as a member of a vulnerable population be immediately moved from solitary confinement and screened for placement in an alternative unit (e.g., residential treatment unit, close observation unit, medical unit), though restrictions may go into effect before alternatives are in place (see Pathway 2 for further discussion). HB 1312 also stipulates a person pending investigation of a disciplinary offense must be considered for release to the general prison population. The bill also requires DOC to develop plans for providing step-down and transitional units to return people held in solitary confinement back into the general population.

DOC staff, staff from other state department of corrections, and researchers noted that separating some people from the general population for disciplinary/behavioral action would still be necessary (personal communications, June 2021). For example, some people held in MAX Custody “represent substantial management challenges (e.g., histories of repeated attacks on staff or of serious mental illness).”¹⁶ Researchers from University of California, Irvine noted that some persons held in DOC IMU settings “had repeatedly assaulted staff, repeatedly seriously harmed themselves, or repeatedly committed serious rule violations as soon as they were released from the IMUs in self-described efforts at sabotage [for the purpose of returning or remaining in the IMU].”¹⁶ HB 1312 may still allow the use of solitary confinement in some of these instances; however, key informants noted that some provisions of HB 1312 related to allowable use of solitary confinement are unclear (personal communications, May-June 2021). For example, the bill states that a person who is incarcerated may not be placed in solitary confinement unless there is a reasonable cause (e.g., threats, conduct) to believe they would pose a substantial risk of immediate serious harm to themselves or someone else and a less restrictive intervention would be insufficient to reduce the risk. Key informants raised questions about what is meant by “reasonable cause,” “substantial risk,” and “less restrictive” (personal communication, May-June 2021). They noted that providing clarity around these terms would limit potential loopholes or unintended consequences and ensure alignment with the intent of HB 1312 (personal communication, May-June 2021).

All key informants stated that HB 1312 would likely decrease the number of people held in solitary confinement in DOC state prisons (personal communications, June 2021). No key informant felt that HB 1312 would increase the number of people held in solitary confinement. Therefore, based on past and current DOC reform efforts, bill provisions, and information from key informants, we have made the informed assumption that HB 1312 would likely decrease the number of people who are currently held or could potentially be held in solitary confinement in DOC state prisons.

Amount of time people are held in solitary confinement

As part of past reform efforts, DOC reduced the maximum time limit a person can be held in Administrative Segregation (Ad Seg) from 47 days to 30 days.¹⁴ DOC administrative data from 2002 to 2017 show a sustained decrease in the length of stay in solitary confinement that “represents a reduction in average lengths of IMU stays of more than four months.”¹⁶ However, while average lengths of stay have decreased, cumulative length of stay (i.e., as a result of multiple placements) and the percentage of the general prison population being held in solitary confinement has increased.¹⁶ HB 1312 would further restrict the number of consecutive days someone may be held in solitary confinement to no more than 15 days and limit the number of

cumulative days someone may be held in solitary confinement to no more than 45 days in a fiscal year.

Current DOC policy stipulates that a person may be held in Ad Seg for no more than 30 days while an investigation into an alleged infraction is being conducted.⁴¹ According to current DOC policy, “in extraordinary situations, the Superintendent may request an extension from the [Mission Housing Administrator (MHA)] of up to 7 days beyond 30 days served” in Ad Seg.⁴¹ If approved, the Ad Seg Hearing Officer is required to update the person on their status every 7 days when they have been on Ad Seg status for more than 30 days.⁴¹ Additionally, DOC policy states that in cases where a person is waiting to be transferred to another facility or IMU, they may be retained in Ad Seg for a maximum of 14 additional days pending transfer.⁴¹ Key informants shared that extensions may also be granted to accommodate ongoing investigations (which do not have a specific time frame), lengthening the time a person may be held in Ad Seg beyond 30 days (personal communication, May 2021). For example, the investigation of one person alleged of engaging in a riot took 66 days to complete.¹¹ The person was found not to have committed the alleged infraction, yet they were held in solitary confinement for a total of 90 days before being transferred to another DOC state prison.¹¹ Another person was held in solitary confinement for 55 days while an investigation was conducted before being found not to have committed an infraction.¹¹

The provisions of HB 1312 limiting the time someone may spend in solitary confinement would likely eliminate the potential for extensions due to lengthy investigations (personal communication, May 2021). Specifically, provisions of the bill state that a person may not be placed in solitary confinement pending investigation of a disciplinary offense unless they pose a serious and imminent danger to themselves, staff, other people in the general prison population, or the public (e.g., violence, escape). The bill also stipulates a person pending investigation of a disciplinary offense must be considered for release to the general population every 24 hours and may not be held for more than 15 consecutive days.

HB 1312 also sets additional time limitations relating to solitary confinement. For example, the bill specifies that a person may not be held in emergency confinement for more than 24 consecutive hours and for no more than 72 cumulative hours in a 30 day period, and a person may not be placed in involuntary protective custody for more than 72 hours.

Some key informants shared potential concerns about time limitations. Key informants representing researchers and community organizations expressed concern that people may be moved out of solitary confinement after 15 days and then moved immediately back in (personal communication, May 2021). They were also concerned that people may still be held in segregation, but with slightly increased time out of cell (e.g., 19 hours versus 20 hours in cell), thereby not technically meeting the definition of solitary confinement detailed in HB 1312 (personal communication, May-June 2021). Researchers emphasized the importance of not simply delineating the amount of time spent outside a cell, but envisioning the quality of conditions, experiences, resources, programming, etc. available to those held in solitary confinement or other alternative settings to support them moving back into the general prison population and ultimately returning to community (personal communications, May-June 2021) (see Pathway 2 and Other Considerations for further discussion). Key informants also stated that

ongoing oversight and monitoring of the use of solitary confinement would be important to ensure the intent of the proposed provisions are met. Specifically, real-time monitoring of the use of solitary confinement rather than annual reporting could identify instances where the use of solitary confinement does not align with the intent of HB 1312 (personal communication, May 2021).

Key informants representing staff from DOC and the North Dakota Department of Corrections and Rehabilitation (DOCR) also shared that, while not common, some people may refuse to leave solitary confinement (personal communications, May-July 2021). DOC shared there are approximately 23 people who are self-segregated in solitary confinement in Washington State prisons who refuse to leave segregation (personal communication, DOC, July 2021). Staff from DOC and North Dakota DOCR stated that some people cite anxiety-based reasons to remain in solitary confinement (e.g., segregation eliminates potential challenging interactions with other people in the general prison population) (personal communication, May-July 2021). Staff from both correctional systems felt that forcibly removing someone from solitary confinement could be detrimental to their health and safety and could create dangerous situations (personal communications, May-July 2021). For example, key informants shared that some people who refuse to leave solitary confinement have stated that, if forced to leave, they would commit a violent act (e.g., assault staff) or a serious rule violation in order to return to solitary confinement (personal communications, May-July 2021). Staff from North Dakota DOCR emphasized the need for flexibility to provide sufficient time for people to receive necessary behavioral interventions to help them safely return to the general prison population (personal communication, July 2021).

Overall, while key informants expressed concerns that HB 1312 may not reduce the amount of time held in solitary confinement for all people, the bill would likely decrease the amount of time held in solitary confinement for some people. Therefore, based on past and current DOC reform efforts, bill provisions, and information from key informants, we have made the informed assumption that HB 1312 would likely decrease the use of solitary confinement for some number of people who are incarcerated in DOC state prisons.

Would decreased use of solitary confinement for people who are incarcerated improve health outcomes for people who are incarcerated or were formerly incarcerated?

There is strong evidence and it is well-accepted by the scientific community that people who are held in solitary confinement have worse health outcomes while incarcerated and after release to community. In 2013, the American Public Health Association declared solitary confinement a public health issue that causes significant mental suffering, creates barriers to medical and mental healthcare, and creates conditions that deteriorate health.¹⁸ A summary article from the American Journal of Public Health stated that, “nearly 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.”²¹ A systematic review and meta-analysis related to the mental health impacts of solitary confinement concluded that, “solitary confinement is associated with the psychological deterioration of [people who are incarcerated]. This effect appears to be beyond that of general incarceration or presence of prior mental illness. Thus, solitary confinement may pose significant harm for [people who experience it].”²³ In 2020, the United Nation’s Special

Rapporteur stated, “the severe and often irreparable psychological and physical consequences of solitary confinement and social exclusion are well documented and can range from progressively severe forms of anxiety, stress, and depression to cognitive impairment and suicidal tendencies.”¹⁹

Generally, evidence shows an association between placement in solitary confinement and symptoms of increased psychological distress, including increased risk of depression, anxiety, panic attacks, paranoia, posttraumatic stress disorder (PTSD), psychotic experiences, cognitive impairment, social withdrawal, mood symptoms, somatic symptoms, hypersensitivity to external stimuli, perceptual disturbance, hostility, aggression, violence, self-harm, self-injurious behavior, and death by suicide.^{3,8,18,21-24,42} A 2018 study found that “prisoners who had spent time in solitary confinement were three times as likely to exhibit symptoms of [PTSD] than those who had not.”²⁴ Among people with mental health concerns, solitary confinement has been shown to exacerbate psychological deterioration, reclusiveness, social withdrawal, psychosis, self-harm, PTSD, and death by suicide.²⁶ In the New York State prison system, “the rate of suicide was more than five times higher for people in solitary confinement than in the general prison population between 2015 and 2019.”⁴² A 2020 study of people who are held in solitary confinement in Washington State found that “after anxiety and depression, the third most common significant health symptoms experienced by [people held in solitary confinement] were ‘somatic concerns,’ defined by the [Brief Psychiatric Rating Scale (BPRS)] as ‘concerns over present bodily health’.”⁸ A study by the University of California, Irvine found that people held in IMUs “frequently experienced: clinically significant symptoms of depression, anxiety, and guilt; serious mental illness and self-harming behavior; IMU-induced symptoms of social isolation, loss of identity, and sensory hypersensitivity; skin irritations and weight fluctuations; un-treated and mis-treated chronic conditions; and musculoskeletal pain.”¹⁶ A 2019 study with people in California prisons found that the incidence of hypertension among people in solitary confinement was almost three times higher than for those held in maximum-security general population units (47.5% vs. 16.5%).⁴²

Contrary to this body of evidence, a 2010 longitudinal study with 247 males incarcerated in the Colorado prison system evaluated the impacts of solitary confinement on psychological distress, and “results of this study are largely inconsistent with [researcher’s] hypotheses and the bulk of literature that indicates [solitary confinement] is extremely detrimental to inmates with and without mental illness.”⁴³ However, the comparison group consisted of people who had been held in solitary confinement and released back to the general prison population following their Ad Seg hearing.⁴³ People were held an average 30 days in solitary confinement prior to their Ad Seg hearing.⁴⁴ More current research has suggested that being held in solitary confinement for more than 10 consecutive days may cause psychological distress.²¹ Therefore, it is possible that people who were held in held solitary confinement and released back to the general population still experienced high levels of psychological distress, which could skew the study results.⁴⁵

Key informants also shared that the provision of healthcare and mental healthcare for people held in solitary confinement is challenging (personal communication, May 2021).¹⁸ For example, key informants explained that the process people use to request healthcare in solitary confinement is different than in the general population. Communication to request healthcare in solitary confinement often must go through correctional officers, which may violate confidentiality or

reduce the likelihood that the communication is given to the medical team. Additionally, healthcare may be provided at cell front (i.e., through the door to the cell), making it difficult for healthcare providers to adequately assess individuals and maintain confidentiality (personal communication, DOC, June 2021). For example, key informants shared that weekly mental health checks are typically completed at cell fronts, which do not provide conditions for privacy or confidentiality (personal communications, June 2021). DOC staff providing mental healthcare to people held in solitary confinement estimate that they see between 5 to 10 people in a private confidential setting per week and can be responsible for cell front rounds for between 50 to 100 people housed in Ad Seg or MAX Custody (personal communications, DOC, June 2021).

During the 2019 Coronavirus (COVID-19) pandemic, DOC policy required that people with COVID-19 symptoms be separated from the general population in quarantine/medical isolation. This resulted in people experiencing quarantine in their cells or being moved to medical isolation units. Additionally, unit-wide or facility-wide lockdowns were also used for quarantine (personal communication, DOC, May 2021). Researchers have noted that, “in many correctional facilities, the only available spaces for implementing quarantine or medical isolation are those typically used for punishing people with solitary confinement.”⁴⁶ Key informants shared that these units in DOC state prisons were not built for emergency public health protocols and living conditions could exacerbate health concerns (e.g., poor ventilation) (personal communication, May 2021). Key informants also stated that the negative conditions of solitary confinement deterred many people from reporting disease symptoms, which likely contributed to the transmission of COVID-19 among people who were incarcerated as well as the medical and dental staff treating them (personal communication, May 2021).

Researchers have further explained this challenge: “use of isolation to curb transmission of COVID-19 in correctional facilities will complicate the emerging crisis, as [people who are incarcerated] become reluctant to report symptoms for fear of being moved to solitary confinement, those who do report symptoms will be forced to endure an experience known to cause psychological and physical harm, and system-wide unrest will be triggered in institutions where fears about being placed in medical isolation could run rampant. Yet, quarantine and medical isolation in response to COVID-19 are necessary to halt the spread of infection; without them, containment of disease transmission will be exceedingly difficult if not impossible, posing significant health risks to [people who are incarcerated], correctional healthcare providers, security staff, and the families and communities to which workers return at the end of each shift.”⁴⁶ Moreover, “the use of punitive isolation during the COVID-19 [pandemic]—including indeterminate system-wide facility lockdowns where people cannot communicate with their families, exercise outside, participate in programming, or interact with healthcare professionals—will deter people from reporting symptoms, in turn threatening the health of all those who work in jails and prisons.”⁴⁶ Regardless of quarantine location, key informants stated that people who are incarcerated experienced higher levels of anxiety and stress due to isolation, concern about their own health, concern about the health of family members and loved ones, and other restrictions (e.g., decreased visitations) as a result of the pandemic (personal communication, DOC, May 2021). Surveys with people held in IMUs found that individuals “experienced barriers to communication—especially restricted visitation possibilities and limited phone access—as some of the hardest parts of [being held in IMU]. Both [a person’s] mental health and their re-entry prospects deteriorate when family ties and social bonds fray.”¹⁶

Lastly, University of California, Irvine found that, “upon release back into the general prison population, [people held in DOC IMUs] continued to deal with the ongoing mental and physical challenges experienced while in the IMU.”¹⁶ Research has also shown that “exposure to restrictive housing is associated with an increased risk of death during community reentry.”²⁶ A study with approximately 300,000 people who were incarcerated and released to community in North Carolina over a 15 year period found that, “compared with individuals who were incarcerated and not placed in restrictive housing, those who spent any time in restrictive housing were more likely to die in the first year after release...especially from suicide...and homicide. They were also more likely to die of an opioid overdose in the first 2 weeks after release...”²⁶ Specifically, “post-release mortality (from all causes, including suicide, murder, and drug overdose) associated with previous time in solitary confinement” found “people who had spent time in solitary confinement in North Carolina between 2000 and 2015 were 24% more likely to die in their first year after release than former prisoners who had not spent time in solitary confinement.”⁸ The study also found a dose-response relationship, such that people who experienced two or more placements in solitary confinement and those who spent more than 14 consecutive days in solitary confinement had a greater risk of death after release to community.²⁶

Similarly, a study of people who were held in solitary confinement while imprisoned in Denmark found that those who had spent time in solitary confinement had significantly higher mortality within five years of being released from prison compared to those who had never spent time in solitary confinement (4.5% compared to 2.8%, respectively).⁴⁷ After adjusting for possible confounders, “results suggested an association between solitary confinement and elevated mortality due to non-natural causes of death [i.e., accidents, self-harm, and violence].”⁴⁷ Of those in the study who spent time in solitary confinement, nearly 69% had spent one week or less in solitary confinement over the course of their incarceration.⁴⁷ Overall, the study showed that “[relatively] short periods in solitary confinement were linked to elevated post-release mortality and that these elevated mortality rates were confined to non-natural causes.”⁴⁷

Since there is strong evidence and it is well-accepted that people who are held in solitary confinement have worse health outcomes while incarcerated and after release to community, decreasing use of solitary confinement for people who are incarcerated would likely reduce negative health outcomes associated with solitary confinement.

Would decreased use of solitary confinement decrease reincarceration?

There is strong evidence that decreased use of solitary confinement would decrease reincarceration.[§] According to DOC, the 3-year “return to institutions” rate (based on 2016 releases) was 33.5%, suggesting that approximately one-third of people who are released from DOC state prisons experience reincarceration.

[§] The published literature uses the term ‘recidivism’ to refer to various measures, spanning from supervision revocations (i.e., technical violations like failing to meet with a supervision officer) to new felony convictions. Research findings vary depending on which measures are evaluated.¹ The term ‘recidivism’ will be used for accuracy as appropriate. However, the literature and key informants stated that ‘reincarceration’ is more accurate and demonstrates the systemic nature in which those with fewer resources (e.g., people of color, those of low socioeconomic status) are more likely to be reincarcerated than those with greater access to resources.

Theoretically, researchers have posited three main explanations for why solitary confinement may increase risk of reincarceration. First, people with mental health concerns are disproportionately held in solitary confinement and “untreated mental health conditions can disrupt the...reentry process, presumably leading to increased risk of recidivism.”¹ Second, people with specific past offending behaviors (e.g., gang involvement) and rule infractions are more likely to be held in solitary confinement, which may “signal chronic behavioral problems that can lead to increased risk of recidivism” and continued infractions after release to community.¹ Third, lack of access to programming in solitary confinement may also increase the risk of recidivism.¹

Research examining this relationship has generally focused on three main areas: whether time spent in solitary confinement impacts reincarceration; whether length of time held in solitary confinement or number of placements impacts reincarceration; and whether return to community directly from solitary confinement impacts reincarceration. These associations have been evaluated in multiple prison systems.

In 2007, researchers from the University of Washington conducted a retrospective study to determine the impacts of solitary confinement on recidivism. They matched people held in Washington State IMUs with individuals held in the general prison population. They found that 53% of people held in solitary confinement and released to community recidivated compared to 42% of those who were incarcerated overall.²⁵ However, people who were released to community directly from solitary confinement (without first returning to the general prison population) accounted for the difference in rates and were twice as likely to recidivate as those released first back to the general prison population.²⁵ People held in solitary confinement who were first released back to the general prison population experienced similar recidivism rates as individuals who had not been held in solitary confinement.²⁵ Moreover, people held in solitary confinement and released directly to community recidivated sooner and at higher rates. For example, people held in solitary confinement committed a new felony about 12 months after release compared to 27 months for those who were first released back to the general prison population or who had not been held in solitary confinement.²⁵ The authors found that group (i.e., solitary confinement direct-release; solitary confinement released first to general prison population; not held in solitary confinement) was more strongly associated with recidivism than infraction rate or time spent in solitary confinement.²⁵

A more contemporary study with approximately 300,000 people who were incarcerated and released to community in North Carolina over a 15 year period found that people who were held for any time in solitary confinement were more likely to recidivate.²⁶ The study also found a dose-response relationship, such that people who had greater exposure to solitary confinement (i.e., two or more placements in solitary confinement; more than 14 consecutive days in solitary confinement) had a greater risk of reincarceration within one year of release.²⁶ Additionally, data from the Bureau of Justice Statistics showed that people who had been previously incarcerated were significantly more likely to be held in solitary confinement compared to those who were not previously incarcerated (20% versus 13.4%),²⁷ suggesting that experiences of solitary confinement and reincarceration may be cyclic and decreasing one may decrease the other.

A study in Ohio evaluated the impacts of solitary confinement on four measures of recidivism (i.e., rearrest within 1 year of release, felony rearrest within 1 year of release, reincarceration within 7 years of release, and reincarceration for a new crime within 7 years of release).⁴⁸ The authors concluded that solitary confinement was associated with increased odds of recidivism.⁴⁸ Specifically, they found that solitary confinement “has the largest magnitude in effect on return to prison within 7 years...and return to prison for a new crime within 7 years. Increases in the predicted probability of return to prison within 7 years...range from 13-20% for returning to prison and 11-17% for returning to prison for a new crime.”⁴⁸ They also found that people who were held in solitary confinement within 6 months prior to release had higher mean levels of recidivism than those who were held in segregation earlier in their sentence,⁴⁸ suggesting return to the general prison population prior to release may decrease recidivism.

Lastly, a study with 6,502 people held in solitary confinement in Minnesota Department of Corrections state prisons and released to community in 2014 found that those who spent any time in solitary confinement “had [statistically significantly] higher rates of supervision revocations, new arrests, and new convictions compared to [people] who spent no time in [solitary confinement].”¹ Specifically, 46% of people “who spent as little as one day in [solitary confinement] were revoked from supervision, compared to just 33% of [people] who did not spend any time in [solitary confinement]”; 53% of people who were held in solitary confinement were rearrested, compared to 46% of people who were not held in solitary confinement; and 22% of people held in solitary confinement were convicted of a new felony, compared to 19% of people who were not held in solitary confinement.¹ People who were released directly to community from solitary confinement had significantly higher rates of all three measures of recidivism than people who first returned to the general prison population.¹ In addition, “an increase in the proportion of [a person’s] confinement time spent in [solitary confinement] more than doubled the expected incidence of supervision revocations...That is even after controlling for several other factors, including mental health, prior behavior, and participation in programming.”¹

While the literature noted that research on the association between solitary confinement and reincarceration is still emerging, available evidence suggests that risk of reincarceration is higher for people who are held in solitary confinement. Additionally, evidence suggests that risk of reincarceration may decrease if people are transferred back to the general population prior to release, and HB 1312 would prohibit someone from being released directly from solitary confinement to community. Therefore, there is strong evidence that HB 1312 would likely decrease reincarceration for some people.

Would decreased reincarceration improve health outcomes?

There is very strong evidence indicating that involvement in the criminal legal system is linked to poor health outcomes.²⁸⁻³⁴ Criminal legal system contact can be measured by a number of indicators including, but not limited to, arrest, conviction, and incarceration.^{49,50} A large body of evidence supports the association between incarceration and poor health outcomes. People who are incarcerated are more likely to experience chronic medical conditions, infectious diseases, lower self-rated health, increased psychiatric disorders, and a greater risk of mortality upon release.^{36,50,51} Research shows that people with a history of incarceration have a significantly greater likelihood of major depression, life dissatisfaction, and mood disorders when compared

to people who do not have a history of incarceration^{49,51} and that effects persist after release. Analysis of a contemporary cohort's criminal legal system contact and mental health over time found arrest and incarceration, but not conviction, are independently associated with poor mental health.⁴⁹ Therefore, decreasing reincarceration and further involvement in the criminal legal system has the potential to improve health outcomes.

Pathway 2: Alternatives to solitary confinement

Would requiring DOC to undertake rulemaking to establish alternatives to solitary confinement result in DOC undertaking rulemaking and developing and implementing such alternatives?

We made the informed assumption that requiring DOC to undertake rulemaking to establish alternatives to solitary confinement would result in DOC undertaking rulemaking and developing and implementing such alternatives. This informed assumption is based on information from key informants representing DOC.

HB 1312 would require DOC to adopt certain regulations, policies, and procedures, including plans for providing step-down and transitional units, programs, and staffing for people held in solitary confinement as well as regulations establishing less restrictive interventions to solitary confinement. The bill would also allow DOC to undertake any additional rulemaking required to implement provisions. Key informants representing DOC stated that if HB 1312 passed, the department would undertake rulemaking to establish alternatives to solitary confinement (e.g., programming, housing, other interventions). However, with the transition to a new secretary of DOC in May 2021, it is unclear how changes in DOC leadership may impact the department's priorities (personal communication, OCO, August 2021). Some work to establish alternatives is already in progress (personal communication, DOC, July 2021).

Since the early 2000s, DOC has worked to reduce the use of solitary confinement at state prisons and to shift staff culture related to solitary confinement (personal communications, May-June 2021).¹⁶ As part of this work, DOC has made and is currently working on reforms to restrict the use of solitary confinement, including developing and implementing alternatives. DOC has a workplan of restrictive housing initiatives that the agency is planning, developing, and implementing for 2021 and 2022.¹⁰ Initiatives include alternatives to solitary confinement such as: opening alternative pods (e.g., Limited Privilege Pods; Transfer Pods); making policy adjustments (e.g., reducing maximum time allowed in Ad Seg, increasing out of cell time, granting Earned Time); repurposing beds away from restrictive housing; eliminating disciplinary segregation; establishing an emerging adults unit for people aged 18 to 25 years; allowing congregate recreation; and expanding Cognitive Behavior Change programs.¹⁰ In July 2021, DOC opened transfer pods in IMUs at three state prisons (i.e., Monroe Corrections Center, Stafford Creek Corrections Center, and Washington Corrections Center).¹⁰

While HB 1312 provides DOC with rulemaking authority to establish less restrictive interventions to solitary confinement, the bill does not specify alternative programming or interventions or specify alternatives for separating people from the general prison population. There is little research on alternatives to solitary confinement, and DOC prioritized current and planned reforms based on input from staff, community-based organizations, and researchers who

have previously or are currently working with the agency to restrict the use of solitary confinement (personal communication, DOC, July 2021). The provisions of HB 1312 would allow DOC to continue to prioritize and implement initiatives that are in progress and planned.

However, DOC noted that initiatives currently in progress may not be implemented by August 2022 (the implementation date specified in HB 1312) as the agency needs time to plan for, implement, or expand alternatives (e.g., to other state prisons) or to implement supporting changes to staffing and infrastructure (personal communication, DOC, July 2021). Key informants explained that alternatives may require changes to DOC staffing, infrastructure, or facilities. For example, DOC is working toward a February 2022 goal of increasing out of cell time for people held in solitary confinement to at least 4 hours per day.¹⁰ Key informants noted that this change will require an additional 61.8 new correctional officers and 8 to 10 additional mental health staff (personal communication, DOC, July 2021). Similarly, key informants representing DOC staff providing mental health services to people held in solitary confinement noted that if people with mental health needs were moved to alternative housing units, additional clinical staff capacity would likely be necessary to provide treatment in alternative settings (personal communications, DOC, June 2021). Key informants also stated that DOC may need to create more recreation yards, classrooms, alternative housing units, etc. (personal communication, DOC, June 2021). While a fiscal note for HB 1312 is not available from DOC,⁵² some of these changes may require additional funding from the Legislature (e.g., capital funds), which could impact implementation timelines (personal communication, DOC, May-June 2021). DOC staff also noted that any legislatively-mandated, specific alternatives would likely impact current implementation timelines and prioritization and could delay work that is in progress (personal communication, DOC, July 2021).

Therefore, there is the potential that restrictions to solitary confinement could go into effect before alternatives were in place or fully implemented. Some key informants representing DOC staff and researchers suggested that restricting the use of solitary confinement without having alternatives in place could result in negative unintended consequences, including the potential for escalated or increased violence, negative impacts to the safety of individuals and staff, or detrimental impacts to shifts made in staff culture (personal communications, June-July 2021). Key informants from the Oregon Department of Corrections (ODOC) reiterated that restricting use of solitary confinement without opportunities to change staff culture and use alternative tools could negatively impact reform efforts as well as the health and safety of staff and people who are incarcerated (personal communication, ODOC, July 2021). However, leadership and staff at the North Dakota DOCR shared that their directive to significantly reduce the population held in Ad Seg required changes to be implemented nearly overnight and without alternatives in place first (personal communication, DOCR, July 2021), and data show that DOCR reduced the population held in solitary confinement by 90% and did not see increased violence across the facility.⁵³

Overall, we made the informed assumption that DOC would likely continue to implement planned alternatives, would undertake policy changes and rulemaking to establish alternatives to solitary confinement as specified in HB 1312, and would develop and implement such alternatives.

Would DOC undertaking rulemaking and developing and implementing alternatives to solitary confinement result in people experiencing such alternatives?

We made the informed assumption that DOC undertaking rulemaking and developing and implementing alternatives to solitary confinement would result in some number of people experiencing such alternatives while incarcerated. This informed assumption is based on information from key informants representing DOC and other state departments of corrections.

HB 1312 specifies that a medical provider must screen people who otherwise would have been held in solitary confinement (i.e., for violence, threats) to determine if they are a member of a vulnerable population. A person determined to be a member of a vulnerable population must be removed from solitary confinement and placed in an appropriate alternative setting (e.g., residential treatment unit, close observation unit, psychiatric facility, medical unit, or some other unit). Though not specified in bill provisions, this would likely require DOC to develop and use a screening tool to determine if a person is a member of a vulnerable population. While some gold standard or validated tools may exist to screen people to determine if they are a member of a vulnerable population, researchers have noted that these tools may not be appropriate for use with people held in prison or in solitary confinement. For example, researchers working with DOC explained, “if we study people in solitary confinement solely with instruments validated with non-incarcerated populations, such as the [Brief Psychiatric Rating Scale (BPRS)], we may fail to capture the extent of...psychological distress [for people who are incarcerated]. A respondent’s rating on a given symptom may not be ‘high enough’; symptoms may not be experienced within the instruments designated time frame; or the discursive strategies [people who are incarcerated] use to articulate their suffering may not correspond with clinical language”.¹⁶ Researchers have noted that it would be valuable to use mixed methodology, including the use of validated screening instruments (when available), interviews with the person held in solitary confinement, clinician observations, staff observations, and medical files to accurately screen individuals.¹⁶

Additionally, screening must be conducted consistently and for all people held in solitary confinement, and there is some evidence to suggest that screening may not accurately identify members of vulnerable populations. For example, although policies within the federal prison system prohibit the holding of prisoners with disabilities in solitary confinement, nationally, prison officials continue to “‘coerce people not to identify as disabled or make it dangerous for people to identify as disabled,’ such as removing mentally ill [people] from their medications in order to neutralize their mental health diagnoses.”⁵⁴ Key informants representing community organizations in Washington State also suggested that the seriousness of mental health conditions may be downgraded for some people before they are placed in solitary confinement (personal communication, May 2021).

Moreover, the National Alliance on Mental Illness (NAMI) stated that, “there may be unique dynamics at play once people enter the criminal [legal] system that contribute to even greater racial [inequities] in the screening, evaluation, diagnosis and treatment of people with mental health problems...evidence shows that mental health screening tools used by jails reproduce racial [inequities], resulting in fewer Black and Latinx people screening positive and thus remaining under-referred and undetected in the jail population.”⁵⁵ Evidence from the Bureau of Justice Statistics shows that Blacks are less likely to be identified as having a mental health

problem and less likely to receive access to mental health treatment once incarcerated.^{55,56} Therefore, depending on how screening is developed and implemented, some people who are part of a vulnerable population may continue to be held in solitary confinement and may not experience alternatives.

HB 1312 also specifies that members of vulnerable populations must be placed in an appropriate alternative setting. However, DOC noted that some alternatives may not be implemented by August 2022 (the implementation date specified in HB 1312) (personal communication, DOC, July 2021). For example, DOC intends to open a special unit for emerging adults aged 18 to 25 years in 2022.¹⁰ They noted this will require developing new policies and procedures, providing staff training, and identifying a location for the unit.¹⁰ If a unit is not implemented prior to restrictions in solitary confinement, it is unclear what alternative setting may be most appropriate for emerging adults.

Lastly, there has been limited research or formal evaluation related to alternatives to solitary confinement. While DOC has implemented some alternatives (e.g., transition units), there is little data and no evaluation about the use and impacts of these alternatives. However, key informants representing researchers and DOC, ODOC, and North Dakota DOCR stated that systems will place people where beds are available (personal communications, June-July 2021). Therefore, if there are fewer solitary confinement beds, there will be fewer people held in solitary confinement (personal communication, June 2021). For example, North Dakota DOCR explained that, “in 2013, we had added on to our maximum security facility, increasing the bed count by 40%. With this, we built a new [Ad Seg] unit. Our old unit had 60 beds. We added 48 more. In less than 18 months, we were at full capacity in all of our units.”⁵³ ODOC noted that opening transition pods increased vacancy in solitary confinement units, allowing them to transition solitary confinement beds back to the general population and resulting in fewer beds available for solitary confinement, which in turn reduced the number of people held in solitary confinement (personal communication, ODOC, July 2021).

While these are only two examples and participation in alternatives will likely depend on screening and the type of intervention, we made the informed assumption that opening transition pods or creating alternative programming would result in some number of people who are incarcerated experiencing such alternatives.

Would experiencing alternatives to solitary confinement improve conditions of confinement for people who are incarcerated?

There is unclear evidence of how experiencing alternatives to solitary confinement would impact conditions of confinement for people who are incarcerated since restrictions to solitary confinement may be implemented before alternatives to solitary confinement are in place, and since conditions of and effects of alternative interventions compared to those of solitary confinement are unknown.

Some key informants representing DOC and researchers suggested that restricting the use of solitary confinement without having alternatives in place could result in negative unintended consequences, including the potential for escalated or increased violence, negative impacts to the safety of individuals and staff, or detrimental impacts to shifts made in staff culture (personal

communications, June 2021). However, North Dakota DOCR found that reducing the population held in solitary confinement did not increase violence across the facility.⁵³

While HB 1312 provides DOC with rulemaking authority to establish less restrictive interventions to solitary confinement, the bill does not specify alternatives for separating some people who are incarcerated from the general prison population. There has been limited research related to alternatives and corresponding conditions to solitary confinement. However, Vera has compiled a list of 24 promising practices and safe alternatives to reduce the use of solitary confinement based on strategies that have been implemented in state prison systems.⁵⁷ Though not comprehensive of all reform efforts, alternative promising practices include reforms related to housing and segregation options; conditions of confinement; accountability and transparency; entry criteria and admissions; exit criteria and strategies; and staff training.⁵⁷

Two states (Colorado and New York State) have enacted legislation creating specific alternatives to solitary confinement (unpublished data, NCSL, June 2021). In 2014, Colorado enacted legislation creating a step-down unit and requiring alternative housing for people with serious mental illness (unpublished data, NCSL, June 2021). In 2021, New York State passed [Senate Bill S2836](#) restricting solitary confinement and creating alternative options (i.e., establishing residential rehabilitative confinement options with increased unrestrained out-of-cell time, interaction in congregate settings, and access to work and educational opportunities).²⁰

Other states have implemented reforms to restrict the use of or to create alternatives to solitary confinement without enacting specific legislation (personal communication, June 2021). In a 2019 policy brief, Vera stated that 27 state prison systems reported having transitional units and/or step-down programs (the two most common alternatives to solitary confinement) that serve as less-restrictive housing options between solitary confinement and the general prison population.⁵⁸ Vera noted that, “transitional units or programs can serve as a way to move people out of restrictive housing and into a less-restrictive environment as quickly as possible while still maintaining safety. In addition, such units can provide programming and treatment to address any unmet needs (such as mental health needs) and promote positive behavioral change, and can allow meaningful socialization and group activity to help people become reaccustomed to being around others.”⁵⁸ They noted a number of elements to ensure effectiveness, including staff culture change; adequate staffing and infrastructure; access to programming to meet individual needs/behaviors; progressively less restrictive conditions; individualized pathways out of transitional units; and appropriate placement back into the general prison population.⁵⁸ The report stated that transitional or step-down programs run the risk of creating cyclic systems which prevent people from returning to the general population (e.g., preventing individuals from progressing to the next phase; demoting individuals for violations; lacking effective programming to ensure successful return to general population).⁵⁸

The AMEND research group at University of California, San Francisco partners with state prison systems to change staff culture using “dignity-driven and public health-oriented correctional practices from Norway.”⁵⁹ As part of this work, some state prison systems have experienced culture change, reductions in the use of solitary confinement, and implementation of alternatives to solitary confinement. Oregon State Penitentiary worked to reduce the use of disciplinary segregation but did not see large changes until after implementing efforts to change staff culture

(personal communication, ODOC, July 2021). The prison worked to increase staff discretion and communication to expand the options for dealing with disciplinary violations. For example, rather than placing a person in solitary confinement for an infraction, correctional officers have discretion to use other tools like issuing a warning, assigning extra work, requiring a person to write an essay, or instituting a “cell-in” which creates some restrictions (e.g., limiting outdoor rec time), while still allowing a person to attend work and other programming (personal communication, ODOC, July 2021). Oregon State Penitentiary also increased the discretion of hearing officers and superintendents to limit the amount of time a person spends in solitary confinement (e.g., a superintendent can release someone from solitary confinement earlier than provided timelines) (personal communication, ODOC, July 2021). Finally, any person assigned to solitary confinement meets with a counselor to discuss the underlying cause for an infraction and completes an accountability worksheet to develop a personalized plan to address behaviors (personal communication, ODOC, July 2021). Oregon State Penitentiary found that these changes have led to increased vacancy in solitary confinement units (i.e., reduced use), decreased misconduct reports, and a general positive shift in the feel or atmosphere of the prison (personal communication, ODOC, July 2021).

North Dakota DOCR also worked to reduce the use of solitary confinement. Following the expansion of their Ad Seg Unit in 2013, data showed the unit was nearly at capacity, placement in Ad Seg was not changing behaviors, and the rate of readmission to Ad Seg had increased (personal communications, DOCR, July 2021). Staff received a directive from leadership to immediately and significantly reduce the number of people held in Ad Seg and to reimagine the unit (personal communication, DOCR, July 2021). As a result, DOCR introduced a number of alternatives and significantly restricted entry criteria into solitary confinement. For example, previously, involvement in two fights would have resulted in a person being held in Ad Seg for up to 6 months. Now, residents involved in the fights may participate in a mediation session and return to the general prison population within 24 hours (personal communication, DOCR, July 2021).

For cases where the risk to others or disruption of orderly running of the institution is too great (assault on staff, homicide, etc.), DOCR implemented the Behavior Intervention Unit (BIU) program in the fall of 2015.⁵³ The purpose of the BIU is to remove someone from the general population and create an environment where staff can work with them on personalized behavioral interventions designed to help them handle conflict without violence and address underlying behaviors.⁵³ BIU programming is designed to help people develop positive, respectful relationships with staff and others. The model includes skill groups that meet three times weekly; extra out-of-cell time for those who attend all three group sessions; pro-social skill practice with custodial and behavioral health staff; and verbal and tangible incentives to increase interaction, encourage participation, improve motivation, and acknowledge performance of pro-social skills.⁵³ Staff receive additional training (e.g., motivational interviewing) and are expected to build trusting relationships with residents through friendly conversation, pro-social skill practice, recreational activities, etc. as part of a dynamic security approach (personal communication, DOCR, July 2021). Each week, the multidisciplinary team that oversees BIU placements reviews reports and determines whether a person is ready to focus on a new skill, to transfer to the Administrative Transition Unit (ATU), or to return to the general prison population. The pathway and time spent in each unit are tailored to a person’s progress rather than a set amount

of time (personal communications, DOCR, July 2021), and “the length of stay should only be for the time necessary to maintain a safe and secure facility.”⁵³

The new programming and operational changes decreased the number of people held and the length of stay for those who met criteria for entry into the BIU. Prior to the COVID-19 pandemic, the BIU population was about 19% of the previous Ad Seg population,⁵³ with as few as 8 people assigned to the unit (which could house as many as 108 people) (personal communication, DOCR, July 2021). The “other 81% of the population previously isolated in [Ad Seg] are still in the prison system, but they are handled safely in the general population or in the residential mental health facility.”⁵³ Additionally, by maintaining consistent staffing regardless of the number of people in Ad Seg, operational costs did not change, and “[staff] were able to improve [the] overall individualized care and significantly reduce the cost associated with responses to the unit due to disruptive behavior.”⁵³ As a result, DOCR has achieved a marked reduction in restrictive housing census, bed-days, and readmissions. For example, readmission rates to Ad Seg decreased from 39.2% before implementing changes to 20.4% under BIU programming.⁵³

Some DOCR leadership and staff shared that they were initially fearful and concerned that transferring people out of Ad Seg to the general prison population would merely transfer disciplinary problems to another unit (personal communications, DOCR, July 2021). However, successful implementation of entry criteria allowed custodial and behavioral staff to safely reduce the population housed in BIU. Key informants shared that the biggest initial challenge was developing buy-in from both staff and people who were incarcerated (personal communications, DOCR, July 2021). However, data from DOCR show that, while the overall prison population has increased over time, the number of people held in Ad Seg (now BIU) decreased, and did not cause increased violence across the facility.⁵³ DOCR leadership and staff noted that the data has helped increase buy-in to the program and has had a broader positive impact on the facility in general (personal communication, DOCR, July 2021).

While efforts by Oregon and North Dakota departments of corrections suggest that alternatives to solitary confinement have reduced the number of people held in solitary confinement, there has been little formal evaluation measuring the reduction in use of solitary confinement, conditions of confinement, or impacts on staff and people who are incarcerated. Key informants stated that some alternatives could be more harmful than existing solitary confinement conditions, rules, and procedures (personal communication, June 2021). Evidence indicates that the general opacity of prison systems, administrative discretion, and demonization of people who are incarcerated have undercut attempted reforms federally, in other states, and internationally.⁵⁴ For example, although policies within the federal prison system prohibit the holding of prisoners with disabilities in solitary confinement, some evidence suggests that prison officials may pressure people not to identify as disabled.⁵⁴ Evidence from Texas and California indicate that initiatives to reduce the use of solitary confinement have led to the creation of programs that largely mirror the same isolating conditions under new branding.⁵⁴ Similarly, “in Canada, where...courts have declared solitary confinement unconstitutional and the federal government has passed legislation claiming to abolish solitary confinement, practical conditions of solitary confinement persist...with more robust procedural protections preceding placement in those conditions.”⁵⁴

Therefore, since restrictions to solitary confinement may be implemented before alternatives to solitary confinement are in place, and since conditions of and effects of potential alternatives compared to those of solitary confinement are unknown, it is unclear how HB 1312 may impact conditions of confinement for people who are incarcerated and DOC staff.

Would improved health outcomes for people who are incarcerated or were formerly incarcerated decrease health inequities?

The potential impact of HB 1312 on health inequities is unclear. Data about people held in solitary confinement is limited, and key informants representing the Office of Corrections Ombuds (OCO), researchers, and community organizations noted there are DOC data limitations by disability status, gender identity, mental health status, race/ethnicity, and sexual orientation (personal communications, May-July 2021). However, available evidence from Washington State and nationally suggests that multiple groups are disproportionately held in solitary confinement, and inequities exist by age,^{2,27} gender identity,⁶⁰ mental and behavioral health status,^{23,27,61} and race/ethnicity.^{14,27} It is well-documented that these groups may experience worse health outcomes.

There is also limited research evaluating how restricting solitary confinement may impact people with various identities. For example, we did not find any research showing how restricting solitary confinement may impact who is held in solitary confinement by age, gender identity, mental and behavioral health status, or race/ethnicity. While HB 1312 specifies that people who are members of a vulnerable population must be placed in an alternative setting, the bill does not specify a screening tool to determine if a person is a member of a vulnerable population and existing tools may not be appropriate for use with people held in prison or in solitary confinement.¹⁶ Depending on how screening is developed and implemented, some people who are members of a vulnerable population may continue to be held in solitary confinement. Moreover, HB 1312 may still allow the use of solitary confinement if there is a reasonable cause (e.g., threats, conduct) to believe the person would pose a substantial risk of immediate serious harm to themselves or someone else and a less restrictive intervention would be insufficient to reduce the risk. Key informants raised questions about what is meant by “reasonable cause,” “substantial risk,” and “less restrictive” (personal communication, May-June 2021). Overall, HB 1312 may still result in people being held in solitary confinement and it is unclear how provisions of the bill may impact various groups.

Lastly, it is well-documented that people of color have disproportionate contact with the criminal legal system across all age groups and at all stages of involvement,⁶²⁻⁶⁵ and are more likely to be held in solitary confinement.^{14,27} HB 1312 does not address the underlying systems of oppression and racism that perpetuate inequities in the criminal legal system. Since people of color are currently disproportionately held in solitary confinement, there is the potential that these individuals would continue to disproportionately be held in solitary confinement even with restrictions in place.

Therefore, due to limited research on how restricting solitary confinement may impact different groups; the intersectionality of overlapping identities; current inequities due to racism in the criminal legal system; and continued opportunities for people to be held in solitary confinement, it is unclear how restricting the use of solitary confinement may impact equity for people who

are incarcerated or were formerly incarcerated. Further discussion about inequities due to racism and by age, mental and behavioral health status, and gender identity are provided below.

Inequities due to racism

It is well-documented that people of color have disproportionate contact with the criminal legal system across all age groups and at all stages of involvement,⁶²⁻⁶⁵ and are disproportionately held in solitary confinement.^{14,27} In a 2012 report, the Research Working Group, Task Force on Race and the Criminal Justice System, convened to address racial inequities in Washington’s criminal legal system, concluded that, “Washington State criminal [legal] practices and institutions find that [race/ethnicity] influence criminal [legal] outcomes over and above [crime] commission rates.”⁶⁶ The Task Force found “that [racial/ethnic] bias distorts decision-making at various stages in the criminal [legal] system, contributing to disparities.”⁶⁶ Researchers who have worked with DOC noted there may also be racial disproportionality for who gets written up for a disciplinary or behavioral infraction while incarcerated and who gets diverted to alternative programming (e.g., mental health programming) instead of being held in solitary confinement (personal communications, June 2021).

These inequities are not inherent to a person’s identity. Rather, inequities are influenced by social determinants that systematically marginalize groups due to their identity. Risk of incarceration is influenced by social determinants of health like racism, which contribute to inequities in policing (i.e., over-policing communities of color), socioeconomic status (e.g., restrictive housing policies which limit opportunities for families of color to build generational wealth), and educational opportunities. Inequities can also be exacerbated or alleviated by intersecting identities. For example, “national data indicate emerging adults have the most racially disparate [criminal legal] system outcomes of any age group.”⁶⁷ One study found that in 2012, the rate of incarceration in either a state or federal prison among people aged 18 to 24 years was nine times greater for Black males than for white males.⁶⁸

People of color are disproportionately represented among people who are incarcerated in DOC state prisons. Key informants representing OCO noted DOC data limitations related to race/ethnicity, and explained that race/ethnicity data is not self-reported (i.e., race/ethnicity are recorded by DOC staff) and people have been misidentified such that a higher proportion of people are recorded as white (personal communication, May 2021). According to DOC point in time data, on July 31, 2021, the general prison population was 55% non-Hispanic White, 17% non-Hispanic Black, 6% American Indian or Alaska Native, 3% non-Hispanic Asian, 1% non-Hispanic Pacific Islander, 1% non-Hispanic other race, and 16% of Hispanic ethnicity.³⁹ The Hispanic population was disproportionately overrepresented in both Ad Seg (23%) and MAX Custody (23%).³⁹

Researchers from the University of California, Irvine found that, “while [DOC] had some success in reducing IMU use, especially in reducing average lengths of stay, the racially disproportionate impact of the IMU has increased dramatically since 2002. The racial disproportion of the IMU actually peaked in 2014, when the IMU population had recently declined.”¹⁶ They noted that, “the racial disproportionality in IMU placements raises questions about the relationship between race, gangs, and prison behavioral histories.”¹⁶ Administrative data from 2002 to 2017 also show “both Hispanic [people] and Hispanic affiliated gang members

are increasingly over-represented in the [MAX Custody] population relative to their representation in the general prison population.”¹⁶ Specifically, from 2002 to 2017, “Hispanic-affiliated gang membership in the general prison population doubled from 4[%] to 8[%] and in the [MAX Custody population] doubled from 21[%] to a peak of 40[%] in 2014.”¹⁶ Between 2015 and 2017, Hispanic people “were 2-3 times as likely to be in the IMU as in the general prison population.”¹⁶ In 2020, Hispanic/Latino people remained overrepresented in restrictive housing (20% of the population in restrictive housing compared to 15% of the general prison population).¹⁴

Vera reported that, “the majority of Hispanic men in restrictive housing are flagged with [a security threat group (STG)] affiliation. [DOC] believe this affiliation, and involvement in large scale violent incidents...are impacting this overrepresentation [of Hispanic people in solitary confinement]. DOC data (July 31, 2021) indicate STG members, affiliates, and suspects were two times more likely than the general population to be held in Ad Seg and three times more likely to be held in MAX Custody.”³⁹ Further analysis is needed to determine the relationship between STG activity and [restrictive housing] placement, the relationship between race/ethnicity and [restrictive housing] placement, the efficacy of the STG flag including any bias that may play a role, and any policies or practices that may disproportionately impact the Hispanic population.”¹⁴ For example, members, affiliates, and suspects of Norteños were nearly two times more likely to be held in MAX Custody than other STG groups.³⁹

Overall, researchers have noted that there is little research examining the causes of racial disparities in solitary confinement units.⁴² Theories about what may be causing these disparities include: “policies that implicitly or explicitly target certain racial groups” (e.g., prohibition of specific hairstyles or head coverings associated with particular racial or cultural groups, in which noncompliance is a disciplinary infraction punishable by solitary confinement); “classifications systems, policies, or informal practices that rely primarily on solitary confinement to discipline or manage members or suspected members of [STG] or gangs (many of which are based on racial identity)”; “risk assessments based on criminal history, number of incarcerations, or other characteristics that often correlate with race because of systemic racism and over-policing of communities of color”; and “implicit bias on the part of corrections staff, particularly in areas where they exercise wide discretion (such as disciplinary write-ups and sanctions).”⁴²

A 2020 systematic review found that, “Blacks and [people of color] consistently show lower life expectancies and worse mental health outcomes than whites. Health disparities persist, and are magnified, among the incarcerated population, where people of color are disproportionately represented.”⁸ Communities of color experience worse health outcomes than their white counterparts for many health measures. Poor health outcomes are not inherent to a person’s race/ethnicity, rather they are influenced by determinants of health like racism, which “contributes to social inequities (e.g., poverty) that shape health behaviors, access to healthcare, and interactions with medical professionals.”⁶⁹ Institutionalized racism results in differential access to resources, services, and opportunities, including access to healthcare, by race.⁷⁰ Washington State data showed that Hispanics were most likely to report fair or poor health as compared to all other racial/ethnic groups (36% versus 16% state average).⁷¹

HB 1312 would prohibit a person from being placed in solitary confinement on the basis of race, creed, color, national origin, nationality, or ancestry alone. However, the bill does not address the systemic drivers that contribute to the disproportionate placement of people of color in prison and in solitary confinement. Therefore, as HB 1312 may still allow the use of solitary confinement in some instances, and since people of color are currently disproportionately held in solitary confinement, there is still the potential that people of color would continue to disproportionately be held in solitary confinement even with restrictions in place. Therefore, it is unclear how restrictions to solitary confinement would impact health inequities due to racism.

Inequities by age

Younger people are also more likely to be held in solitary confinement.^{2,27} Specifically, emerging adults ages 18 through 24 years are overrepresented in solitary confinement. According to the Bureau of Justice Statistics, emerging adults were significantly more likely to have been held in in solitary confinement than older people, with 30.9% of people aged 18 through 19 years and 28.3% of those aged 20 through 24 years in federal and state prisons experiencing solitary confinement.²⁷ According to DOC data, as of September 2020, emerging adults made up 22.9% of people in MAX Custody and 15.9% of people in Ad Seg, but 9.1% of the overall incarcerated population.¹⁴ Key informants representing the North Dakota DOCR stated that being under 25 years of age was the greatest predictor of placement in solitary confinement (personal communication, DOCR, July 2021).

A large body of neuroscience literature has demonstrated that the human brain continues to develop well into a person's 20's and that "adult-quality" decision-making ability, self-regulation, and impulse control continues to develop into adulthood.^{37,68} Researchers discuss what is known as the "maturity gap" in emerging adults aged 18 through 24 years where cognitive functioning develops faster than psychosocial capacities and because of this, emerging adults are more likely to engage in risk-seeking behavior, have difficulty moderating their responses to emotionally-charged situations, have poor risk assessment skills, be more impulsive and emotional, and think about short-term rather than long-term consequences.^{37,71,72} Key informants stated that emerging adults in DOC state prisons are more susceptible to pressure from older people who are incarcerated to break rules or act violently in order to "fit in or survive" the prison system, which puts them at risk of committing infractions or behaviors that make them more likely to be held in solitary confinement (personal communication, June 2021). Key informants also shared that emerging adults are also more likely to be placed in solitary confinement based on suspected affiliation or involvement with gang activities (personal communication, June 2021).

Evidence indicates that emerging adults in adult correctional facilities have the greatest risk of being assaulted with those aged 18 through 24 years being the most at risk for victimization.⁷³ Key informants in Washington State confirmed that emerging adults experience violence from other incarcerated people and correctional officers (personal communication, September 2020).

HB 1312 prohibits a person who is a member of a vulnerable population from being placed in solitary confinement, including people 25 years of age or younger. However, HB 1312 may still allow the use of solitary confinement in some instances, and since emerging adults are currently disproportionately held in solitary confinement, there is still the potential that emerging adults

would continue to disproportionately be held in solitary confinement even with restrictions in place. Therefore, it is unclear how restrictions to solitary confinement would impact health inequities by age.

Inequities by mental and behavioral health status

Evidence shows that people with a mental health disorder are more likely to come into contact with the criminal legal system. Data from the Bureau of Justice Statistics found that people “who met the threshold for [serious psychological distress] were more likely than those without [serious psychological distress] to be written up or charged with an assault while incarcerated” compared to people without a mental health concern.⁵⁶ A meta-analysis of 11 studies found a moderate association between any mental health concern and placement in solitary confinement, even after controlling for confounding factors.⁶¹ Further, people with an anxiety or mood disorder or experiencing serious psychological distress were significantly more likely to be held in solitary confinement than those with no mental illness (23.3% and 28.9% respectively, compared to 15.1%).²⁷

Data from Washington State show that people with serious mental illness are overrepresented in DOC restrictive housing. Approximately 20% of people held in IMUs have a serious mental illness designation, compared to 9% of those in the general prison population.²³ In September 2020, 75 people with serious mental illness were held in either Ad Seg (29 people) or MAX Custody (46 people).¹⁴ Many of those in MAX Custody with serious mental illness are in DOC’s SOU, where they receive more intensive mental health treatment.¹⁴ In their 2020 Annual Report, OCO stated “people with serious mental illness reported receiving infractions for behavior while they were in the midst of a mental health crisis, and experiencing barriers to completing programs mandated for their release.”⁷⁴ OCO recommended, “DOC should ensure that those on the mental health caseload receive an expedited investigation, review, and hearing to reduce the total time in restrictive housing [i.e., solitary confinement].”⁷⁴ In its August 2021 “Systematic Report: Mental Health Access & Services” report, OCO recommended that DOC “reduce the frequency of placement and length of stay in any segregated housing, including...SOU, for individuals with mental health conditions” and “explore best practices for successfully housing and treating individuals with behavioral challenges...in a setting that is not IMU or other segregated housing.”⁷⁵ In response, DOC identified its work with Vera and AMEND to reduce its Ad Seg and MAX Custody populations; new, more rigorous consideration process for requested Ad Seg extensions; and efforts to expand its continuum of care through intensive outpatient treatment, which it expects to meet some behavioral health needs in the general prison population.⁷⁵ These approaches are at various stages of development and/or implementation.

HB 1312 prohibits a person who is a member of a vulnerable population from being placed in solitary confinement, including someone who has a mental disorder as defined by [RCW 71.05.020](#), or where there is evidence of a diagnosis of a serious mental illness, a history of psychiatric hospitalization, or a history of disruptive or self-injurious behavior including, but not limited to, serious and/or repeated self-harm that may be the result of a mental disorder or condition. However, evidence suggests that screening may not accurately identify all people with mental health concerns. Research suggests that validated mental health screening tools may not be appropriate for people held in prison or in solitary confinement.¹⁶ Additionally, the National Alliance on Mental Illness (NAMI) stated that, “there may be unique dynamics at play once

people enter the criminal [legal] system that contribute to even greater racial [inequities] in the screening, evaluation, diagnosis and treatment of people with mental health problems...evidence shows that mental health screening tools used by jails reproduce racial [inequities], resulting in fewer Black and Latinx people screening positive and thus remaining under-referred and undetected in the jail population.”⁵⁵ Evidence from the Bureau of Justice Statistics shows that Black people are less likely to be identified as having a mental health problem and less likely to receive access to mental health treatment once incarcerated.^{55,56} Therefore, due to intersecting identities, it is unclear how restrictions to solitary confinement would impact health inequities by mental and behavioral health status.

Inequities by gender identity

Historically, prison housing policies and inadequate programming resulted in LGBTQ+ people being disproportionately held in solitary confinement solely because of their identity.²¹ Results of a 2014 survey of nearly 1,200 LGBTQ+ people in incarcerated settings showed 85% of respondents reported having been placed in solitary confinement at some point during their incarceration, and approximately half had spent two or more years in solitary confinement.⁷⁶ In 2016, the American Correctional Association, which publishes accreditation standards for prisons in the U.S., issued new standards related to solitary confinement which restricted the use of solitary confinement based on gender identity alone.²

Quantitative data documenting gender diversity in prison settings are limited. While DOC tracks gender identity if someone discloses that information, key informants noted that gender diverse people may not feel safe sharing their identity within the prison setting (personal communication, May 2021). For example, several people reported experiencing targeted harassment by DOC staff and other people who were incarcerated after coming out as trans or non-binary.⁶⁰ Key informants estimated there are approximately 150 transgender people in DOC state prisons (personal communication, Disability Rights WA, May 2021).

Based on qualitative data collected by OCO staff, “transgender and gender nonconforming persons report being disproportionately placed in restrictive housing, such as solitary confinement or close observation areas” pending housing decisions, as a result of a disciplinary infraction, or in response to a complaint or Prison Rape Elimination Act (PREA) report.⁶⁰ For example, the OCO Assistant Ombuds for Gender Equity & Reentry “found infraction examples at [Washington Corrections Center for Women] where transgender individuals were punished more harshly than cisgender individuals who engaged in the same behaviors.”⁶⁰ Specifically, key informants shared that transgender people are more likely to be held in solitary confinement than their cisgender peers for the same transgressions (personal communication, May 2021). While people held in women’s facilities are not typically held in solitary confinement, evidence indicates transwomen are more likely to be held in solitary confinement than cisgender women (personal communication, May 2021).

Key informants also shared that transgender people are often placed in solitary confinement reportedly for their own protection following a complaint under PREA. In 2003, the U.S. Congress passed PREA to “provide for the analysis of the incidence and effects of prison rape in federal, state, and local institutions and provide information, resources, recommendations and funding to protect individuals from prison rape.”⁴⁰ The National PREA Standards were

developed to assist prisons and jails in implementing the federal legislation.^{40,77} Standards address prevention, screening, and official response following a report, investigation, etc.⁷⁷ For example, the standard related to post-allegation protective custody ([§115.68](#)) states that “any use of segregated housing to protect [a person who is incarcerated] who is alleged to have suffered sexual abuse shall be subject to the requirements of [§115.43](#) [Protective custody].”⁷⁸ The standard attempts to prevent facilities from automatically or routinely involuntarily segregating people who are incarcerated and alleged to have suffered sexual abuse. It is also meant to ensure those at “high risk for or who have alleged to have suffered sexual abuse are not placed in involuntary segregated housing unless no available alternative means of separation from likely abusers exists.”⁷⁸ Moreover, any protective custody provided should not restrict access to programming, education, and work opportunities “to the extent possible” as “any form of involuntary segregation and restrictions to programming or other privileges can be experienced as punitive.”⁷⁸ The standards require documentation of any limitation on these rights as well as periodic review to determine the continuing need for separation.^{78,79}

Qualitative data collected by OCO indicate that many gender diverse people incarcerated in Washington prisons “do not trust the PREA process and say it often makes things worse by DOC going directly to their abusers for incident interviews, then later dismissing the concern and leaving them in greater danger of harassment or harm.”⁶⁰ In its response, DOC noted that Department of Justice (DOJ) PREA standards require such interviews—as all known alleged victims and known alleged abusers have the right to be interviewed about allegations.⁶⁰ Transwomen shared they “cannot honestly report when they feel unsafe being housed as a woman in a prison for men due to fear of being placed in restrictive housing [i.e., solitary confinement].”⁶⁰ As such, “[t]ransgender survivors in prisons shared that they often keep incidences of rape to themselves or try to heal individually and with their community because it feels safer than going to DOC staff.”⁶⁰

Moreover, key informants shared that almost all complaints filed by trans people in Washington State prisons are auto-marked as PREA, even when the law isn’t relevant (e.g., in instances of non-PREA, gender-based discrimination) (personal communication, May 2021). As a result of filing a complaint, the trans person is placed in Ad Seg (i.e., solitary confinement) while the complaint is investigated. All PREA-related complaints are addressed by DOC Headquarters. Complaints that are determined to not be PREA-related are returned to the referring state prison. However, often facilities do not follow-up on the original non-PREA related complaint (personal communications, May 2021). In such cases, trans people are held in and released from solitary confinement without their original complaint being addressed. As a result, trans people may be less likely to report PREA or other valid complaints for fear of being placed in solitary confinement (personal communication, May 2021). DOC recognizes its “historical gap in identifying concerns brought forth that may or may not have met requirements for investigation under the DOJ PREA standards, which led to individuals’ concerns not being investigated appropriately.”⁶⁰ As part of the DOC’s Resolution Program Manual (RPM) 2021 update, “the RPM now clearly defines what resolution requests are unable to be processed through the Resolution Program and must be referred as a PREA allegation.”⁶⁰ In instances where a request is referred as a PREA allegation and is determined not to meet DOJ PREA standards, “the RPM instructs the individual...to submit a new Resolution Request” so that “their concern will be processed and handled in accordance with the Resolution Program guidelines.”⁶⁰

Transgender people have higher rates of depression, anxiety, eating disorders, self-harm, and suicide.⁸⁰ The American Psychological Association (2008) and the American Psychiatric Association, stated in 2012: “Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression....[Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.”⁸⁰ Evidence shows that gender-based discrimination affecting access to healthcare services is a strong predictor of suicide risk among transgender persons⁸¹ and lack of access to gender affirming care may directly contribute to poor mental health. Additionally, transgender people face high rates of violence, including physical attacks, sexual assault, and intimate partner violence.⁸² Among the 2015 survey respondents, 54% experienced some form of intimate partner violence, 47% were sexually assaulted at some point in their lifetime, and 10% had been sexually assaulted in the past year.⁸²

HB 1312 would prohibit a person from being placed in solitary confinement on the basis of, domestic partnership or civil union status, affectional or sexual orientation, sex, or gender identity or expression alone, which may decrease the use of solitary confinement for some people. Since LGBTQ+ people are disproportionately held in solitary confinement and HB 1312 may still allow the use of solitary confinement in some instances, there is still the potential that LGBTQ+ people would continue to disproportionately experience solitary confinement even with restrictions in place. Therefore, it is unclear how restrictions to solitary confinement would impact health inequities by gender identity.

Overall, due to limited research on how restricting solitary confinement may impact different groups; intersectionality of overlapping identities; current inequities due to racism in the criminal legal system; and continued opportunities for people to be held in solitary confinement, it is unclear how restricting the use of solitary confinement may impact equity for people who are incarcerated or were formerly incarcerated.

Other considerations

This Health Impact Review focused on the most direct pathways between provisions in the bill and health outcomes and health equity. Evidence for other potential pathways are discussed below.

Impacts on conditions of solitary confinement

While the provisions of HB 1312 may reduce the use of solitary confinement for people who are incarcerated in DOC state prisons, some people may still be held in solitary confinement. As part of Pathway 1, we evaluated the potential impact provisions of HB 1312 may have on conditions of solitary confinement for people who are held in Ad Seg or MAX Custody.

[WAC 137-32-030](#) outlines conditions of confinement for people held in Ad Seg or MAX Custody, including conditions related to adequate lighting and ventilation; meals; personal hygiene; communication; reading material; legal representation; recreation; access to healthcare services; and access to other programming.⁹ The WAC is currently (as of July 2021) open for

rulemaking and is expected to be finalized in August 2021 (personal communication, DOC, July 2021).¹⁰ HB 1312 specifies certain conditions for solitary confinement that are similar to conditions outlined in the existing WAC (personal communication, DOC, June 2021), including conditions related to environment (e.g., ventilation, lighting, temperature, sanitation); time outside of cell; access to programming (e.g., recreation, education, therapies, activities, social interaction); access to food, water, and other basic necessities; and access to healthcare services. Since it is unclear how provisions may change conditions from the status quo, and since some changes may require capital funding and infrastructure modifications (e.g., building additional classroom spaces) (personal communication, June 2021), this pathway was ultimately not included in the Logic Model.

Researchers have noted that, “many factors contribute to how [people] experience their confinement and how they are affected by it, including: the physical conditions of confinement; level and form of contact with the outside world; in-cell provisions; access to programs and activities; medical and mental health treatment; staff-prisoner relationships; and the ethos and atmosphere in the prison. These factors will all impact [the person’s] experience of solitary confinement...”⁴⁵ Key informants shared that, in Washington State, these circumstances of solitary confinement vary by DOC state prison. For example, people may have various access to resources or programming (e.g., commissary, library, healthcare, classrooms for group meetings) depending on the prison facility and infrastructure (personal communication, May 2021).

Key informants noted that access to resources, programming, and related opportunities may also have additional impacts. For example, access to work and educational programs are “usually necessary for achieving good time credit and being paroled.”⁷⁶ Therefore, those who “serve much of their sentence in isolation, are also more likely to serve the maximum (or longer) of a non-life sentence.”⁷⁶ Key informants also shared that people held in solitary confinement, even for short durations (e.g., 24 hours) may lose all of their personal belongings, which may impact their personal finances as well as impact their ability to go to school or work (personal communication, May 2021). Lastly, key informants suggested that, if conditions of solitary confinement improved, people may be more likely to report disease symptoms, which could help to reduce transmission of disease in the future (personal communications, June 2021).

The study by University of California, Irvine found that people held in solitary confinement in DOC state prisons “largely trusted DOC staff to meet their basic needs for food and care and perceived staff as responsive to requests, kites [i.e., requests for healthcare, including mental healthcare], and grievances.”¹⁶ Additionally, from 2002 to 2017, access to and the diversity of programming offered on IMUs increased.¹⁶ However, people in solitary confinement were frustrated by long waitlists for programs.¹⁶

Overall, since it is unclear how provisions may change conditions from the status quo and some changes may require additional funding or infrastructure modifications, this pathway was ultimately not included in the Logic Model.

Impacts on staff

This review also evaluated the potential impact HB 1312 may have on correctional facility officers, healthcare professionals, mental health clinicians, and other staff working in IMUs. It is

unclear whether HB 1312 may increase, maintain, or decrease the current number of staff assigned to solitary confinement units at DOC state prisons (personal communications, DOC, June 2021). A fiscal note is not available from DOC.⁵² One key informant suggested that certain provisions of the bill (e.g., required daily mental health checks, increased time out of cell) could require additional staff to be assigned to solitary confinement units (personal communication, May 2021). Other key informants suggested that if the number of people held in solitary confinement decreased, staffing requirements could also decrease (personal communication, June 2021). Meanwhile, key informants from North Dakota's DOCR shared that they maintained the same staffing levels in their BIU regardless of whether 8 or 108 persons (capacity) were assigned to the unit (personal communications, July 2021). While it is unclear how HB 1312 may impact staffing needs, reducing the use of solitary confinement and changing the conditions of solitary confinement may also impact the health of correctional officers, clinicians, and other staff.

A report by the National Institute of Justice stated that, "many scholars conclude that employment as a [correctional officer] is among the most dangerous and life threatening of all professions, including law enforcement."⁸³ Correctional officers "are required to interact with and supervise potentially dangerous [people] in relatively unsafe and secluded surroundings."⁸³ Moreover, "prisons [are] dangerous environments that carry increased risk of harm to the people working in them."⁸³ Correctional officers may experience multiple work-related dangers, including exposure to infections and communicable diseases, prison gangs, disruptive people, contraband items, riots, and people in distress.⁸³ They experience increased risk of physical and mental health outcomes, including increased risk of injury, heart disease, diabetes, high cholesterol, hypertension, stress, burnout, etc.⁸³ For example, a 2011 study found that 31% of correctional officers reported serious psychological distress, which is twice the rate of the general public.⁸³ A 2012 study found that 27% of correctional officers reported symptoms of PTSD, which is almost twice the rate of combat Veterans (14%).⁸³ Research found that correctional officers experience death by suicide at twice the rate of the general public.⁸³ Lastly, correctional officers also experience lower life expectancy; "the average lifespan of individuals in this line of work was 59 years, some 16 years below the national average of 75 [years]."⁸³

The report also included a review of literature examining correctional officers' perception of workplace safety issues, including exposure to infectious disease, risk of injury, and risk of victimization by people who are incarcerated or coworkers. Studies found that correctional officers perceived their risk of various safety-related issues to be high. One study found that 92.2% of officers believed they were at risk of contracting Hepatitis B or C.⁸³ Another study found that between 57% and 73% of officers believed they were at risk of victimization by people who were incarcerated.⁸³ Researchers also found that "higher levels of stress were significant predictors of three variations of officer burnout: depersonalization, emotional exhaustion, and job ineffectiveness."⁸³ Moreover, "many studies have found safety and wellness risks within the correctional environment to significantly influence officers' desire to use administrative sick leave as well as their desire to resign."⁸³ A study examining data from 2000 to 2008 found that 16.2% of correctional officers resigned after only three years on the job, and "elevated rates of officer turnover and absenteeism can lead to higher [people who are incarcerated]-to-officer ratios and greater numbers of...assault."⁸³ Overall, resulting "staff shortages and officer absences from work can create a cycle whereby low officer-to-inmate

ratios and high turnover in officer staffing threaten the effective implementation of a correctional facility's security mandates."⁸³

The National Institute of Justice noted that previous research has found that "some officers are assigned to more dangerous units of the prison (e.g., [Ad Seg]), which can increase their risk of physical and mental health problems."⁸³ While there is limited research evaluating how working specifically in solitary confinement units affects corrections staff, the Association of State Correctional Administrators has noted that solitary confinement "places substantial stress on both the staff working in those settings as well as the [people] housed in those units."² Stressful conditions include "frequent loud shouting and banging, flooded or feces-covered cells, and instances of interpersonal and self-inflicted violence."⁴² Evidence from "the field suggests that working in solitary is especially taxing: [...] frequent reports of staff being reluctant to work in solitary confinement, [...] even quitting on the spot after being assigned to those units."⁴²

Specific to Washington State, researchers from the University of California, Irvine completed 90 written surveys and 77 interviews with DOC custodial and non-custodial staff working on IMUs. Approximately 90% of staff stated they felt loyalty to the restrictive housing unit where they worked and felt "comradery, trust, and professionalism among their colleagues and with immediate supervisors."¹⁶ In addition, staff reported "less day-to-day violence and more person-to-person humanity" as a result of DOC reform efforts to reduce the use of solitary confinement over the past 15 years.¹⁶ However, key informants also shared that people assigned to work on a solitary confinement unit will often report numerous absentee days, or take annual leave, sick time, or unpaid leave while assigned to solitary confinement units (personal communication, May 2021). This may require untrained staff to fill positions. Additionally, staff absenteeism and turnover reduces the number of trained staff working in these units, which could exacerbate circumstances (personal communication, May 2021).

Researchers found that 80% of DOC custodial and non-custodial staff working on IMUs reported that stress impacted their health "some" or "a lot" in the past 12 months.¹⁶ Researchers found 3 primary reasons for high stress levels, including feeling overworked, undervalued, and hypervigilant. For example, 98% of staff agreed or strongly agreed that they "always have to keep in mind that trouble could happen any time."¹⁶ Moreover, "although [DOC staff] felt safe working in the IMU, they overwhelmingly felt hypervigilant (often even unsafe) outside of prison, suggesting that their work *in* the IMU had health and social consequences *outside* of the IMU."¹⁶ Chronic and pervasive levels of stress can also negatively impact physical and mental health outcomes.

Key informants also stated that the welfare of officers may impact the welfare of people who are incarcerated (personal communication, May 2021). Research has shown that correctional officers and clinicians working in solitary confinement units are more likely to perpetrate violence²¹ under conditions that may create a "culture of harm".³ For example, "many litigations have shed light on physical abuse, excessive use of restraints, and mistreatment of mentally ill [people held in solitary confinement while incarcerated] (i.e., Madrid vs Gomez, 1995, Ruiz vs Johnson, 1999 and Valdes vs Crosby, 2006)."³

Solitary confinement has been cited as a tool to protect people who are incarcerated as well as correctional officers (personal communication, May 2021) and is “sometimes required for the sake of safety and institutional order.”¹ However, a systematic review found that solitary confinement is associated with increased hostility, which is “consistent with theories suggesting [solitary confinement] leads to feelings of unjust treatment, frustration, and rage.”³ Authors highlight that “this state could partly explain why [solitary confinement] does not successfully reduce violent misconduct”.³

While HB 1312 would likely have impacts on the health of correctional officers and other staff, since it is unclear how HB 1312 may impact staffing in IMUs, this pathway was not included in the Logic Model.

Annotated References

1. **Clark Valerie A., Duwe Grant. From Solitary to the Streets: The Effect of Restrictive Housing on Recidivism. *Corrections*. 2018;4(4):302-318.**

Clark and Duwe evaluated the impact of solitary confinement (across all levels of security for 30 days or more) on recidivism for 6,502 individuals who were held in solitary confinement in Minnesota Department of Corrections and released to community in 2014. The authors noted that, "many returns to prison can come as the result of rule-breaking, and not law-breaking behaviors." Therefore, they used three measures of recidivism: supervision revocations (i.e., technical violations) (e.g., failing to meet with supervision officer, failing to maintain employment, breaking curfew), new arrests, and new felony convictions within 3 years after release. They noted that studies use various measures of recidivism and "have found varying main effects depending on which recidivism measure was used." Of the 6,502 individuals, 40% had supervision revoked, 48% were rearrested, and 20% experienced a new felony conviction within 3 years of release. The authors also stated that, "restrictive housing [i.e., solitary confinement] is sometimes required for the sake of safety and institutional order." However, solitary confinement has been shown to increase risk of recidivism for three primary reasons. First, solitary confinement is associated with worse mental health outcomes and "untreated mental health conditions can disrupt the prisoner reentry process, presumably leading to increased risk of recidivism." Second, solitary confinement is associated with past offending behaviors and rule infractions which may "signal chronic behavioral problems that can lead to increased risk of recidivism." Third, solitary confinement may increase the risk of recidivism due to the lack of access to evidence-based programming shown to reduce recidivism. The authors evaluated the impacts of the proportion of time spent in solitary confinement as well as whether individuals were released directly to community or returned to the general prison population before release. Of individuals who were held in solitary confinement for at least one day, they spent an average of 15% of their total time in confinement in solitary confinement. Approximately 7% of individuals held in solitary confinement were released directly from solitary confinement to community. The authors controlled for sex, age at release, race/ethnicity, education level, new commitment, total length of confinement, type of offense, post release supervision, mental health status, prior criminal history, and participation in programming. Overall, "there were many significant differences between [people] who spent any time in [solitary confinement] and [people] that did not." Generally, individuals held in solitary confinement were significantly more likely to be male; younger; people of color; lack high school equivalency; have new commitments; have longer average length of confinement; have drug, DWI, and criminal sexual conduct convictions (rather than release violations); experience intensive supervised release; have a mental health condition; experience discipline convictions; be identified as a part of a security threat group (e.g. gang); and participate in a higher average number of effective interventions. Of individuals who spent any time in solitary confinement, "they had [statistically significant] higher rates of supervision revocations, new arrests, and new convictions compared to [people] who spent no time in [solitary confinement]." Specifically 46% of individuals "who spent as little as one day in [solitary confinement] were revoked from supervision, compared to just 33% of [individuals] who did not spend any time in [solitary confinement]"; 53% of individuals who were held in solitary confinement were rearrested, compared to 46% of individuals who were not held in solitary confinement; and 22% of individuals held in solitary confinement were convicted of a new felony, compared to 19% of

individuals who were not held in solitary confinement. Individuals who were released directly to community from solitary confinement had significantly higher rates of all three measures of recidivism than people who first returned to the general prison population. In addition, "an increase in the proportion of an [individual's] confinement time spent in [solitary confinement] more than doubled the expected incidence of supervision revocations...That is even after controlling for several other factors, including mental health, prior behavior, and participation in programming." The authors concluded that solitary confinement "has a limited effect on recidivism. Time spent in [solitary confinement] increased the risk of supervision violations but did not significantly affect the risk of rearrest or reconviction."

2. Administrators Association of State Correctional, Arthur Liman Public Interest Program Yale Law School. Aiming to Reduce Time-In-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms. 2016.

This joint report by the Association of State Correctional Administrators (ASCA) and the Arthur Liman Public Interest Program at Yale Law School documented the use of restrictive housing in the U.S. in Fall 2015 and "provides the only current, comprehensive data on the use of restricted housing." The intent of the report was to: 1) Understand the formal rules governing aspects of the segregation of prisoners in the U.S.; 2) Estimate the number of individuals and demographics of individuals (i.e. race/ethnicity, gender identity, age, mental health status) experiencing solitary confinement; 3) Understand the conditions of solitary confinement; and 4) Summarize the limits on the use of isolation. The report noted that, "prison systems across the [U.S.] separate some prisoners from the general [prison] population and put them into special housing units, typically with more isolating conditions. The reasons for doing so include the imposition of punishment ("disciplinary segregation"), protection ("protective custody"), and incapacitation (often termed "administrative segregation")." Restricted housing is a term used by correctional facilities to collectively refer to forms of segregation (restricted/restrictive housing; protective custody; disciplinary segregation; administrative segregation; special housing units; security housing units; special management units; intensive management; etc.) and is more commonly known as solitary confinement. The report defined restricted housing "as the separation of prisoners from the general population and in detention for 22 hours per day or more, or 15 or more continuous days, in single-cells or double-cells." A previous joint report and survey by the same authors found that, "correctional policies made getting into segregation relatively easy, and few systems focused on getting people out. The criteria for entry were broad." They estimated that in 2014, "some 80,000-100,000 people were...in restricted housing (however termed) in U.S. prisons—or one in every six or seven prisoners" not including individuals incarcerated in jails, juvenile facilities, or immigration and military detention. This report presented data from the 2015 survey with the directors of prison systems with the Federal Bureau of Prisons, all 50 states, the District of Columbia, and the Virgin Islands. Forty-eight jurisdictions had sufficient data to report, including the federal system, 45 states, Washington D. C., and the Virgin Islands, representing 96.4% of the total prison population in the U.S. Across all 48 respondents, 67,442 individuals across the U.S. were held in solitary confinement in federal or state prison systems. The median percentage of the U.S. prison population held in restricted housing was 5.1%. Approximately 17.7% of these individuals had been in restricted housing for 15 days to one month; 28.9% for one to three months; 16.4% for three to six months; 13.0% for 6 months to one year; 13.1% for one to three years; 5.5% for three to six years; and 5.4% for 6 years or more. However, these

numbers do not include all individuals held in solitary confinement in the U.S. Based on the definition of solitary confinement used in the survey and report, these numbers do not include individuals held in solitary confinement for less than 15 consecutive days. Additionally, the survey did not solicit data from or include information from jails, juvenile facilities, military facilities, or immigration facilities. The authors noted, “the dearth of information on county jails is important to underscore because counties were responsible, as of 2016, for 91% of the jails in the [U.S.], and ‘11.4 million individuals pass through jail each year.’”²³ Specific to Washington State, the report found that about 1.7% (274 individuals) of Washington State’s prison population was held in solitary confinement for 22 hours or more per day, for 15 consecutive days or longer. At the time of the survey, approximately 5.8% (16) of these individuals had been in restricted housing for 15 days to one month; 20.1% (55) for one to three months; 24.8% (68) for three to six months; 25.5% (70) for 6 months to one year; 13.5% (37) for one to three years; 5.8% (16) for three to six years; and 4.4% (12) for 6 years or more. The report also provided data for solitary confinement by sex, race/ethnicity, and age. Across 40 jurisdictions that provided data regarding female prisoners, “the jurisdiction reporting the lowest percentage was Washington [State], where approximately 0.1% of the female custodial population (1 out of 1,136) was in restricted housing.” In Washington State, Hispanic men are more likely to experience solitary confinement. Specifically, Hispanic men account for 30% of males in solitary confinement, but only 13% of males in the general prison population. Younger individuals are also more likely to experience solitary confinement. Men 18 to 49 account for 90% of males in solitary confinement, and 80% of males in the general prison population. The report also provides information about vulnerable populations, specifically individuals who experience mental illness, individuals who are pregnant, and individuals who are transgender. The report also documented that “several jurisdictions described making significant revisions to the criteria for entry, so as to limit the use of restrictive housing, as well as undertaking more frequent reviews to identify individuals to return to the general population, thereby reducing the number of people in restricted housing by significant percentages.” The (now former) president of the ASCA stated, “restricted housing places substantial stress on both the staff working in those settings as well as the prisoners housed in those units.”

3. **Luigi M., Dellazizzo L., Giguere C. E., et al. Shedding Light on "the Hole": A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings. *Front Psychiatry*. 2020;11:840.** Luigi et. al. conducted a systematic review and meta-analyses of the psychological effects and mortality rate among people exposed to solitary confinement while incarcerated in correctional settings. Researchers researched PubMed, PsycINFO, Web of Science, and Google Scholar for articles published from inception of databases through March 2020. The systematic review identified 13 studies which met inclusion criteria (e.g., case-control study designs), with a total sample of 382,440 incarcerated persons. Of those, 23% had been exposed to solitary confinement and 96% of the sample originated from the U.S. Studies were excluded if they included persons who volunteered for placement in solitary confinement or if they had significant methodological issues. Studies were classified as High, Moderate, Low, or Very Low quality. "Higher quality evidence showed solitary confinement was associated with an increase in adverse psychological effects, self-harm, and mortality, especially by suicide." The seven studies specifically included in the meta-analyses met inclusion criteria and "either symptoms were reported on a scale to compute standardized mean difference (SMD) or data allowed calculations of odd ratio (OR) for

mortality." Evidence provided by studies included in the meta-analyses were evaluated as high (1 study), moderate (4), and low (2) quality. "[F]ive studies were longitudinal (two prospective and three retrospective) and two were cross-sectional." No publication bias was observed. A "meta-analysis of five studies (n = 4,517) showed a standardized mean difference of 0.45 for general psychological symptomatology, which increased to 0.51 upon outlier exclusion" (i.e., a study with a sample entirely composed of individuals who suffered from a known mental illness). Authors note, "This, along with controlled studies, indicates [individuals] with a known mental illness are not driving the entirety of the association between [solitary confinement] and psychological distress." Results showed small to moderate significant effects for mood (anxiety/depression) (0.41 [CI 95% = 0.19–0.64, p < 0.001]), psychotic (0.35 [CI 95% = 0.18–0.52, p < 0.001]), and aggressivity or hostility symptoms (0.38 [CI 95% = 0.18–0.52, p < 0.001]). A "meta-analysis of two mortality studies (n = 243,050) showed a trend for a moderate effect for mortality by any or unnatural causes (i.e., suicide, homicide, overdose, and accidents)." However, the risk of mortality (i.e., all causes or unnatural causes) were not statistically significant. Researchers concluded, "analyses showed that solitary confinement is associated with the psychological deterioration of [individuals who are incarcerated]. This effect appears to be beyond that of general incarceration or presence of prior mental illness. Thus, solitary confinement may pose significant harm for [people who experience it]." However, "further studies are required to show that exposure to [solitary confinement] can increase risk of post-release death."

4. Assembly United Nations General. A/Res/70/175. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules): Resolution adopted by the General Assembly on 17 December 2015. Vol Seventieth session 2016.

The United Nations General Assembly published the Nelson Mandela Rules outlining standard minimum rules for the treatment of prisoners. A number of the rules address solitary confinement. The rules also define solitary confinement as, "the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days."

5. Inslee Names Cheryl Strange new Department of Corrections Secretary [press release]. 2021.

This press release from the Office of the Governor announces a new secretary of the Washington State Department of Corrections effective May 2021.

6. Prison Facilities. 2021; Available at:

<https://www.doc.wa.gov/corrections/incarceration/prisons/default.htm>. Accessed 4/15/2021.

This webpage provides information about the prison facilities and inmate population.

7. Corrections Washington State Department of. Fact Sheet: Restrictive Housing, Providing Safe and Secure Restrictive Housing. 2020.

This Washington State Department of Corrections (DOC) factsheet provides information about restrictive housing. Eight of the 12 DOC state prisons have restrictive housing units, with the majority of individuals held in solitary confinement at Washington State Penitentiary. DOC states that restrictive housing includes Administrative Segregation (Ad Seg) and Maximum (MAX) Custody. Ad Seg is used to "temporarily remove an [individual who is incarcerated]

from the general population until a timely and informed decision can be made about appropriate housing based on their behavior." Ad Seg may be used if an individual poses a threat to staff or other individuals; requests protection; are being transferred to a more secure facility; poses a risk of escape; or is under investigation for a threatening behavior. MAX Custody is the most restrictive form of housing and "individuals can be placed in MAX Custody when they pose a significant risk to the safety and security of employees, contract staff, volunteers or other individuals, have validated protection needs, or designated individuals with serious mental illness." Data shows that, in 2020, 518 individuals were held in Ad Seg and 423 are held in MAX Custody. DOC stated that use of restrictive housing has not increased as a result of the COVID-19 pandemic. DOC noted 17 guiding principles to reduce the use of solitary confinement. One guiding principle states that, "vulnerable populations--including people with serious mental illness, those with developmental or intellectual disabilities, and aging populations--should be diverted away from restrictive housing, and alternative responses should be utilized."

8. Strong J. D., Reiter K., Gonzalez G., et al. The body in isolation: The physical health impacts of incarceration in solitary confinement. *PLoS One*. 2020;15(10):e0238510.

Strong et al. examined "how solitary confinement correlates with self-reported adverse physical health outcomes, and how such outcomes extend the understanding of the health disparities associated with incarceration." Researchers used a mixed methods approach, conducting semi-structured, in-depth interviews; Brief Psychiatric Rating Scale (BPRS) assessments; and systematic reviews of medical and disciplinary files for subjects. The study sample consisted of a random sample of prisoners (n = 106) in long-term solitary confinement in the Washington State Department of Corrections (DOC) in 2017. In total, 225 individuals incarcerated in IMU (62%), responded to the in-person paper survey, and 106 participated in a random sample for in-depth interviews. Sixty-seven of those approached (n=173) refused to participate in an initial interview, resulting in a 39% refused rate which was comparable to similar studies of people experiencing incarceration. Twenty-five percent of the sample was lost at one-year follow-up (i.e., 4 participant refusals; 21 institutional, out-of-state, and parole transfers precluding follow-up; and one death). The random sample had a mean age of 35 years; mean stay of 14.5 months in IMU; mean of 5 prior convictions resulting in prison sentences; and was 42% white, 12% African American, 23% Latino, and 23% "Other." The interview sample did not significantly differ from the total population held in IMU at the time of the sampling. Researchers also analyzed administrative data for the entire population of prisoners in the state in 2017 (n = 17,943). "In the initial 2017 assessment, all study subjects were housed in IMU. At the time of re-interview in 2018, 52 respondents had moved into the general prison population, while 28 remained in IMU. Of those who were still in IMU in 2018, 21% (6 of 28) reported clinically significant somatic concerns, compared to just 8% of those housed in the general prison population (4 of 52). While the descriptive data appear to demonstrate higher proportions of somatic concern in IMU settings, the difference was not statistically significant at the 95% confidence Level (p = 0.09; Fisher's exact test)." Results of the broader survey of people in IMU showed, "Of the 225 survey respondents, 63% expressed health concerns; 48% were taking medication; 17% had arthritis; and 8% had experienced a fall in solitary confinement. Importantly for the analysis of emerging symptoms in particular, 82% replied 'yes' to the question 'Have you experienced any changes in yourself?' while in the IMU." Physical symptoms experienced in solitary confinement included "(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 conditions and policies."

9. Code Washington Administrative. WAC 137-32-030: Conditions of confinement. 2003.

WAC 137-32-030 outlines conditions of confinement for individuals held in administrative segregation or Maximum Custody. The WAC is currently (as of July 2021) open for rulemaking.

10. Corrections Washington State Department of. Restrictive Housing Initiative Timeline. 2021.

In this document, Washington State Department of Corrections outlines restrictive housing-related initiatives and proposed timelines. Each initiative details locations and proposed implementation dates ranging from July 2021 through 2022 (or to be determined). Initiatives include alternatives to solitary confinement such as: opening alternative pods (e.g., Limited Privilege Pods; Transfer Pods); making policy adjustments (e.g., reducing maximum Ad Seg placement timeframes, increasing out of cell time, granting Earned Time); repurposing beds away from restrictive housing; eliminating disciplinary segregation; establishing an emerging adults unit for 18-25 year olds; allowing congregate recreation; and increasing Cognitive Behavior Change programs.

11. Schrader A. Admin Seg at MCC Report with DOC Response. Olympia, WA: Office of the Corrections Ombuds; July 8, 2021 2021.

This report by the Office of the Corrections Ombuds (OCO) documents its investigation of the placement of an individual incarcerated at the Monroe Correctional Complex (MCC) in Administrative Segregation (i.e., solitary confinement) pending an investigation into allegedly inciting a hunger strike. Found guilty of a 746 hunger strike infraction, he had been housed in solitary confinement since November 3, 2020, even though his sanction (i.e., 20 days cell confinement) was complete. Evidence indicated that the individual was held in solitary for a total of 112 days. As part of the investigation, OCO also "reviewed six months of Administrative Segregation data at Monroe and gathered additional information regarding incarcerated individuals who were held in administrative segregation for an extended period of time." Data showed that multiple individuals were held for an extended period of time in Administrative Segregation at MCC. "OCO does not disagree that disturbances and contraband qualify as security issues", however "the security risk presented by the persons reviewed by OCO did not justify the extended time in administrative segregation." Moreover, "extended time in solitary confinement has significant, negative impacts on incarcerated individuals, impacting their release dates, communication with their families, and health, among other items." Therefore, "the length of time in solitary confinement seems disproportionate to the actual threat of incidents and the persons involved." OCO recommended DOC create a hard 30-day deadline by which an individual must be released from solitary confinement and evaluate investigations that result in IMU placements for "efficiency and whether the security threat justifies the length of state in administrative segregation." It acknowledges that DOC may "need to deploy additional staff resources and/or provide greater oversight and approval by DOC HQ as to what constitutes a 'significant threat' such that an extended investigation is required." In response to the OCO report and recommendations, Secretary Cheryl Strange wrote, "Mandatorily reducing the allotted 30-day timeframe across the board, regardless of circumstance and situation, contains risk for both

incarcerated individuals and staff, and the department cannot agree with the recommendation." However, DOC is interested in "pathways for review and consideration...to ensure that individuals are housed in segregation for the least amount of time, preferably less than 30 days." In response to the recommendation to speed up investigations, DOC agrees and will consider requesting additional staffing resources and providing additional oversight as to what constitutes "an extraordinary situation" which requires an extended investigation.

12. Corrections Washington State Department of. Restrictive Housing Level System Grid. Olympia, WA: Washington State Department of Corrections; 2020.

This Washington DOC Restrictive Housing Level System Grid details Program Activities that individuals held in either Administrative Segregation or Maximum Custody may access. Level 1 indicates those activities available to all individuals held in Restrictive Housing. Access to activities available to Levels 2, 3, and 4 are based on time someone has spent in Restrictive Housing as well as their behavior.

13. Herzog Rob. Restricted Housing Units Policy Exceptions. Olympia, WA: Washington State Department of Corrections; 2021.

This memo from Rob Herzog, Assistant Secretary Prisons Division outlines exceptions to DOC's policies DOC 320.200 Administrative Segregation, 320.250 Maximum Custody Placement/Transfer/Release, and 320.255 Restrictive Housing.

14. Justice Vera Institute of. Senate Bill 5413, An Act Relating to Solitary Confinement. In: Senator Jeannie Darneille; Senator Joe Nguyen; Senate Committee on Human Services RR, ed. Letter ed: Vera Institute of Justice; 2021:1-14.

In this letter to the Washington State Senate Committee on Human Services, Reentry & Rehabilitation, the Vera Institute of Justice (Vera) provides an overview of the Washington State Department of Correction's (DOC) progress (2019-2020) made through the "Safe Prisons, Safe Communities: From Isolation to Dignity and Wellness Behind Bars" initiative. Goals of the partnership were to: 1) decrease the total restrictive housing population by at least 20[%] by the end of the partnership, and at least 50[%] in four years; 2) significantly reduce the length of time people spend in restrictive housing, moving towards a long-term goal of ending prolonged restrictive housing (more than 15 days); 3) improve conditions in restrictive housing, including but not limited to a less isolated environment, additional out-of-cell time, opportunities for meaningful human contact, and access to programs and services; 4) eliminate the use of restrictive housing in response to non-violent/low-level behavior, and eliminate its use for particularly vulnerable populations (e.g., people with serious mental illness); and 5) address racial and ethnic disparities in the use of restrictive housing. The letter describes the technical assistance Vera provided DOC to identify and address drivers of restrictive housing use in Washington State. The document details collaboratively developed goals, data on progress, context related to the challenges presented by the COVID-19 pandemic, and Vera's recommendations to DOC moving forward.

15. Justice Vera Institute of. Safe Prisons, Safe Communities: From Isolation to Dignity and Wellness Behind Bars Closing Memo - December 2020. Vera Institute of Justice; 2021.

This memo provides a brief summary of progress made by the Washington State Department of Corrections as of December 2020. It also includes recommendations from Vera for strategies the

department should pursue going forward as it works to decrease the total population held in restrictive housing.

16. Reiter K., Chesnut K., Gonzalez G., et al. Reducing Restrictive Housing Use in Washington State: Results from the 2016-2020 Study "Understanding and Replicating Washington State's Segregation Reduction Programs," Contract No. K11273. 2021.

Researchers from University of California, Irvine collaborated with DOC to determine how the agency reduced the use of restrictive housing. As part of this work, they used mixed methodology, including: 1) evaluating administrative data at six snapshot intervals between 2002 and 2017; 2) completing 315 paper surveys with individuals who are held in and DOC staff working in Intensive Management Units (IMUs); 3) conducting 186 interviews with a random sample of individuals held in MAX Custody; and 4) conducting 77 interviews with a convenience sample of staff working in IMUs. They provided themes and main findings in five areas, including: research practices; use of restrictive housing use; conditions of restrictive housing; experiences of staff; and experiences of individuals who are incarcerated. The report also includes recommendations for further policy reform.

17. Sinclair Steve. Letter to Joanna Carns, Office of Corrections Ombuds: Procedures and Practices Strengthened in 2020 by the Department of Corrections. Washington State Department of Corrections; 2020.

Washington State Department of Corrections issued a memo to the Office of Corrections Ombuds reporting major accomplishments during calendar year 2020. Related to restrictive housing, DOC stated that, as of February 2020, they had "reduced total restricted housing population by 9.21%; reduced lengths of stay in Ad-Seg and MAX; and as of December 31, 2019, 62% of people in restricted housing spent an average of less than 30 days. The proportion of people with serious mental illness in restrictive housing has also decreased to include an almost 50% decline of seriously mentally ill individuals in Ad-Seg between December 2019 and June of 2020." They also noted that, "even with COVID-19 response actions in place, DOC continues to reduce its use of restrictive housing to address...disciplinary issues, where appropriate."

18. Association American Public Health. Solitary Confinement as a Public Health Issue. 2013.

In 2013, the American Public Health Association (APHA) declared solitary confinement a public health issue. The APHA stated that solitary confinement causes significant mental suffering, creates barriers to necessary medical and mental health care, and generates risks that health will deteriorate. Solitary confinement increases risk of anxiety, panic attacks, paranoia, cognitive impairment, social withdrawal, somatic symptoms, hypersensitivity to external stimuli, and perceptual disturbances. They recommended that, "[p]atients whose medical or mental health conditions contraindicate placement in segregation should be categorically excluded from solitary confinement, as should juveniles. Correctional authorities should implement policies that eliminate solitary confinement for security purposes unless no other less restrictive option is available to manage a current, serious, and ongoing threat to the safety of others. Punitive segregation should be eliminated. Isolation for clinical or therapeutic purposes should be allowed only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible. Prisoners who are separated from the general population for their

own protection should be housed in the least restrictive conditions possible." APHA noted that it is difficult to fully estimate the number of individuals who experience solitary confinement due to differences in definitions and conditions across jurisdictions.

19. United States: Prolonged solitary confinement amounts to psychological torture, says UN expert [press release]. 2020.

On February 28, 2020, the UN issued a statement from Mr. Nils Melzer, Special Rapporteur on Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment of the United Nation's Human Rights Council. The statement "voiced alarm at the excessive use of solitary confinement by correctional facilities in the [U.S.]" and stated that the Special Rapporteur has continually "shown the extent to which such practices could amount to torture." The Special Rapporteur specifically addressed conditions seen in the Connecticut Department of Corrections. He stated, "the severe and often irreparable psychological and physical consequences of solitary confinement and social exclusion are well documented and can range from progressively severe forms of anxiety, stress, and depression to cognitive impairment and suicidal tendencies. This deliberate infliction of severe mental pain or suffering may well amount to psychological torture." The UN report also stated that the use of solitary confinement for individuals with mental or physical disabilities is prohibited under the UN's 2015 Nelson Mandela Rules.

20. Senate New York State. Senate Bill S2836. 2021.

In 2021, New York State passed the Humane Alternatives to Long-Term Solitary Confinement Act (known as the HALT Solitary Confinement Act). The bill "restricts the use of segregated confinement and creates alternative therapeutic and rehabilitative confinement options; limits the length of time a person may be in segregated confinement and excludes certain persons from being placed in segregated confinement."

21. Cloud D. H., Drucker E., Browne A., et al. Public Health and Solitary Confinement in the United States. *Am J Public Health*. 2015;105(1):18-26.

Cloud et al. state that most state prison systems do not collect or report reliable data about the average duration individuals who are incarcerated spend in solitary confinement. Specifically, "living conditions in solitary confinement are physically unhealthy, extremely stressful, and psychologically traumatizing." The authors also stated that, "because of housing policies and inadequate programming, lesbian, gay, bisexual, transgender, and queer individuals; pregnant women; and people with infectious disease may find themselves in solitary confinement solely because of their identity or medical condition." The authors wrote, "nearly 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" and increases the risk of self-harm, suicide, and violence toward correctional staff. Additionally, correctional officers and clinicians that work in solitary confinement units are at higher risk for injury, psychological damage, and violence. The authors also explained that, "widespread and lengthy solitary confinement has been universally denounced by international human rights and social justice organizations..." moreover "legal scholars and human rights advocates now recognize prolonged segregation as a form of torture..."

22. **Favril Louis, Yu Rongqin, Hawton Keith, et al. Risk factors for self-harm in prison: a systematic review and meta-analysis. *The Lancet Psychiatry*. 2020;7(8):682-691.**

This systematic review and meta-analysis conducted by Favril et al. assessed the risk factors associated with self-harm inside prison. Authors cited evidence that the annual prevalence of self-harm in a prison setting is estimated to be 5-6% among men and 20-24% among women, significantly greater than in the general public (less than 1% of adults per year). Moreover, persons who are incarcerated and self-harm are at "six to eight times increased risk of suicide while incarcerated and remain so after release into the community." Authors searched electronic databases for articles published from the inception of each database through October 31, 2019. They included primary studies involving adults sampled from general prison populations who reported self-harm in prison and a comparison group without self-harm in prison. Thirty-five independent studies from 20 countries were identified. They included a total of 663,735 individuals experiencing incarceration, of whom 24,978 (3.8%) had self-harmed in prison. Studies examined a collective 40 risk factors. The strongest associations with self-harm in a prison setting were suicide-related antecedents. "Prison-specific environmental risk factors for self-harm included solitary confinement (5.6, 2.7–11.6; $I^2=98\%$), disciplinary infractions (3.5, 1.2–9.7; $I^2=99\%$), and experiencing sexual or physical victimisation while in prison (3.2, 2.1–4.8; $I^2=44\%$)." The meta-analysis found the custodial variable most strongly associated with self-harm among individuals who were incarcerated was residing in solitary confinement (odds ratio of 5.6, $p<0.0001$). Overall, "the leading risk factors from each of the five domains were homelessness, being sentenced for 5 years or more, current suicidal ideation, solitary confinement, and childhood sexual abuse." Prospective studies are necessary to explore whether risk factors predict self-harm during the course of incarceration (or if they are perhaps a consequence of self-harm).

23. **Reiter K., Ventura J., Lovell D., et al. Psychological Distress in Solitary Confinement: Symptoms, Severity, and Prevalence in the United States, 2017-2018. *Am J Public Health*. 2020;110(S1):S56-S62.**

Reiter et al. assessed symptoms and measure prevalence of psychological distress among incarcerated people in long-term solitary confinement. Researchers used a mixed methods approach, conducting semi-structured, in-depth interviews; Brief Psychiatric Rating Scale (BPRS) assessments (i.e., tool developed to rate symptom severity in hospitalized psychiatric patients and track changes over time); and systematic reviews of medical and disciplinary files for subjects. The study sample consisted of a random sample of prisoners ($n = 106$) in long-term solitary confinement in the Washington State Department of Corrections (DOC) in 2017. Authors noted that Latinos and gang affiliates were both overrepresented in the IMU sample, likely due to "conflicts among rival Latino factions as an institutional security concern." Overall, the sample was younger, had a more violent criminal history, and faced longer sentences than the general population. The initial sample's mean and median BPRS ratings "suggested mild psychiatric symptoms among the study population at the time of [...] interviews." More specifically, "BPRS results showed clinically significant symptoms of depression, anxiety, or guilt among half [of the] research sample." Additionally, "[a]dministrative data showed disproportionately high rates of serious mental illness and self-harming behavior compared with general prison populations." For example, 19% of respondents had serious mental illness designations, "22% had a documented suicide attempt, and 18% had documentation of other self-harm, all at some point during their incarceration, either before of after their time in the IMU."

Finally, "[i]nterview content analysis revealed additional symptoms, including social isolation [73% of respondents], loss of identity [25%], and sensory hypersensitivity [16%]." At 1-year follow-up, 80 original participants (i.e., 28 in IMU custody and 52 in the general prison population at follow-up) agreed to an interview and BPRS assessment. "For respondents still in the IMU in 2018, all clinically significant symptoms that were prevalent among at least 10% of the population were at least as prevalent in 2018, and 2 clinically significant factor scores were more prevalent [i.e., hallucinations, unusual thought content, and conceptual disorganization; and depression, anxiety, guilt, and somatization]." The study was not powered to establish statistically significant differences between 2017 and 2018 data sets. Overall, authors conclude the findings "highlight the importance of analyzing specific components of BPRS scores, and not only aggregates, which mask variation in both prevalence and severity of specific symptoms." Washington's administrative data show that 20% of the IMU sample have a serious mental illness designation compared to 9% of the general prison population. Qualitative data showed that "people in solitary confinement experience symptoms specific to those conditions not captured in standard psychiatric assessment instruments. Both findings suggest an affirmative answer to the question of whether solitary confinement is associated with more and worse psychopathology than general population confinement."

24. Hagan B. O., Wang E. A., Aminawung J. A., et al. History of Solitary Confinement Is Associated with Post-Traumatic Stress Disorder Symptoms among Individuals Recently Released from Prison. *J Urban Health*. 2018;95(2):141-148.

This cross-sectional study by Hagan et al. "assessed the relationship between solitary confinement [independent variable] and post-traumatic stress disorder (PTSD) symptoms [dependent variable] in a cohort of recently released former prisoners." Baseline data were available from the Transitions Clinic Network, "a multi-site prospective longitudinal cohort study of post-incarceration medical care." Authors used multivariable logistic regression to adjust for potential confounders (e.g., prior mental health conditions, age, and gender). "Among 119 participants, 43% had a history of solitary confinement and 28% screened positive for PTSD symptoms." Specifically, "[t]hose who reported a history of solitary confinement were more likely to report PTSD symptoms than those without solitary confinement (43 vs. 16%, $p < 0.01$)." After adjustment for potential confounders, multivariable logistic regression showed "a history of solitary confinement (OR = 3.93, 95% CI 1.57-9.83) and chronic mental health conditions (OR = 4.04, 95% CI 1.52-10.68) were significantly associated with a positive PTSD screen." Subsequent analyses found "there was no difference in PTSD symptoms between those with longer ([more than] 1 week) and shorter ([less than or equal to] 1 week) periods of solitary confinement." Overall, "experiencing solitary confinement was significantly associated with PTSD symptoms among individuals accessing primary care following release from prison." Authors recommended larger studies be conducted assess the association as the current study cannot determine the direction of the association. "Solitary confinement may be a traumatic event that could lead to PTSD [...] Alternatively, [people] with unrecognized PTSD may have exacerbations of symptoms while incarcerated, which could lead to conflicts that result in punishment and solitary confinement."

25. Lovell D., Clark Johnson L., Cain K.C. Recidivism of Supermax Prisoners in Washington State. *Crime & Delinquency*. 2007;53(4):633-656.

This study was conducted in 2007 in Washington State. Previous research has indicated that individuals held in supermax facilities experience “mental illness, brain damage, or other factors; that needed treatment is often not provided; and that vulnerable inmates are further damaged by sensory deprivation and other disorienting features of the environment.” Lovell et al. conducted a retrospective matched control study to determine whether individuals incarcerated in supermax facilities were more likely to recidivate after release to community. They stated, “given the dearth of knowledge about supermax, however, we believed it important to determine whether supermax prisoners showed higher rates of recidivism than one would expect, based on standard age and criminal history predictors.” They matched individuals held in Washington State intensive management unit facilities with individuals held in the general prison population based on eight predictors of recidivism (e.g. past felonies; past misdemeanors; first-time sex offender; infraction rate; race/ethnicity (Black; Native American/Pacific Islander); felony versatility; index violent felony; age of release; mental health residential time (for individuals identified with serious mental illness only). All individuals had been released to community in 1997 and 1998. Individuals with serious mental illness were four times as likely as other prisoners to be held in supermax facilities. Fifty three percent of individuals held in supermax facilities and released to community in 1997 and 1998 recidivated, compared to 42% of individuals overall. Individuals that were released to community directly from supermax facilities (without being first returned to the general prison population) experienced higher rates of recidivism than those released from the general population and, “the difference between supermax participants and their nonsupermax mates was largely due to supermax participants released directly from supermax into the community when their prison sentences ended.” The “odds of recidivism versus non-recidivism for direct-release offenders were nearly twice the odds for their later-release mates.” Individuals held in supermax facilities that were first released back to the general prison population experienced similar recidivism rates as individuals that were not held in supermax facilities. Moreover, “members of the direct-release group were younger at prison admission and release, committed their first offense at a younger age, had more past misdemeanors, and had much higher infraction rates.” Age at first offense was the greatest predictor of recidivism (which other research has also shown). In addition, individuals held in supermax facilities and released directly to community recidivated sooner. Individuals held in supermax facilities released directly to community committed any new offense about 14 weeks after release (compared to 8 months for later-release mates) and a new felony about 12 months after release (compared to 27 months for later-release mates and for individuals not held in supermax). The authors found that group (i.e. supermax direct-release; supermax delayed-release; non-supermax) was more strongly associated with recidivism than infraction rate or time spent in supermax. The authors concluded, “the principal finding of this study is that supermax assignment did make a significant difference to recidivism, but only for those [individuals] who were held in supermax until the end of their prison sentences” and released directly from supermax facilities into community. Specifically, “these [individuals] committed new felonies sooner and at higher rates than otherwise comparable nonsupermax offenders. Furthermore, they reoffended more quickly than otherwise comparable supermax offenders who weren’t released to the community directly from supermax.” The authors suggested that these findings may be due to two reasons. First, being held in supermax facilities increases psychological distress, which may be mitigated after return to the general population. Second, individuals held in supermax may be “more combative, antisocial, or impulsive than others” which puts them at higher risk of reoffending. The authors

stated, “our study provides evidence against the practice of retaining prisoners in supermax until release that is far stronger than any evidence yet provided of its benefits.”

26. Brinkley-Rubinstein L., Sivaraman J., Rosen D. L., et al. Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA Netw Open*. 2019;2(10):e1912516.

Brinkley-Rubinstein et al. conducted a retrospective cohort study with approximately 300,000 individuals who were incarcerated and released to community in North Carolina from January 2000 to December 2015 to determine the impact of experiencing solitary confinement on recidivism and mortality (i.e. all cause mortality, and death by opioid overdose, by homicide, and by suicide). They controlled for age, prior incarceration, drug-related convictions, violence-related convictions, mental health treatment recommended, mental health treatment received, number of days served in recent sentence, sex, and race. Over the time period, approximately 33% of individuals experienced solitary confinement and 68% of these individuals were placed in restrictive housing for longer than 14 days. Individuals who experienced solitary confinement were more likely to be male, younger, have less than a high school education, have been recommended for mental health treatment, to have received mental health treatment in prison, to have had a violence-related conviction, and to have had a longer sentence. The authors concluded, “exposure to restrictive housing is associated with an increased risk of death during community reentry.” Overall, “compared with individuals who were incarcerated and not placed in restrictive housing, those who spent any time in restrictive housing were more likely to die in the first year after release...especially from suicide...and homicide. They were also more likely to die of an opioid overdose in the first 2 weeks after release...” Individuals who experienced any time in solitary confinement were also more likely to recidivate. The study also considered number of placements in solitary confinement and time spent in solitary confinement. That analysis “suggested that the association of the percent-time spent in restrictive housing during incarceration with mortality after release had a dose-response relationship, such that increasing percent-time spent in restrictive housing was associated with greater mortality after release.” Individuals that experienced two or more placements in solitary confinement had an even greater risk of death or reincarceration. Similarly, individuals who spent more than 14 consecutive days in solitary confinement had a greater risk of all-cause mortality and death by homicide or by suicide and a higher risk of reincarceration within one year of release. Additionally, the association between solitary confinement and death by homicide and reincarceration was higher for nonwhite individuals compared to white individuals. The authors also presented background information demonstrating that solitary confinement of individuals with mental health concerns may result in further psychological deterioration, reclusiveness, social withdrawal, psychosis, self-harm, posttraumatic stress disorder, and suicide.

27. Beck A.J. Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12. Special Report. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2015.

This Bureau of Justice Statistics Special Report presented data on the use of restrictive housing in U.S. prisons and jails in 2011-2012. Using data from the 2011-2012 National Inmate Survey, the Bureau of Justice Statistics estimated approximately 4.4% of individuals who were incarcerated in a state or federal facility were held in restrictive housing on an average day and nearly 20% of individuals had spent time in restrictive housing in the past 12 months. Of

individuals who experienced restrictive housing, Black/African American inmates were statistically significantly more likely to experience solitary confinement than whites (20.8% compared to 16%). Approximately 28.3% of individuals aged 20 through 24 years experienced solitary confinement, which is statistically significantly higher than inmates in any age bracket 30 years of age or older. Individuals who were lesbian, gay, or bisexual were statistically significantly more likely to experience solitary confinement than heterosexuals (27.8% compared to 17.5%). Individuals who experienced prior incarceration as a juvenile or adult were statistically significantly more likely to experience solitary confinement compared to those that were not reincarcerated (20% versus 13.4%). Individuals with an anxiety or mood disorder or experiencing serious psychological distress were statistically significantly more likely to experience solitary confinement than individuals with no mental illness (23.3% and 28.9% respectively, compared to 15.1%).

28. London A, Myers N. Race, incarceration, and health. *Research on Aging*. 2006;28(3):409-422.

London and Myers conducted a review of the literature around health and other outcomes for incarcerated individuals. They highlighted research that indicates that black Americans have worse health outcomes than other racial/ethnic groups and are also disproportionately represented in the justice system. The authors also outlined data indicating the high rates of injury in jails and prison as well as the high rates of communicable disease among incarcerated and formerly incarcerated individuals. In addition, they highlight research that indicates that incarceration is associated with lower educational attainment, lower income, higher rates of unemployment, and higher involvement in jobs with high risk of injury or exposure to hazardous working conditions. Evidence also indicates that incarceration is associated with divorce and separation of families.

29. Turney K, Wildeman C, Schnittker J. As fathers and felons: Explaining the effects of current and recent incarceration on major depression *Journal of Health and Social Behavior*. 2012;53(4):465-481.

Turney et al. analyzed data from the longitudinal Fragile Families and Child Wellbeing study. The researchers found that currently and recently incarcerated fathers are more likely to report a change in employment status, separation from a child's mother, a change in relationship quality, and depression. The association between incarceration and depression remained significant even after controlling for variables such as demographic characteristics and history of depression.

30. Wu E, El-Bassel N, Gilbert L. Prior incarceration and barriers to receipt of services among entrants to alternative incarceration programs: A gender-based disparity. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*. 2012;89(2):384-395.

Wu et al. collected data from a random sample of adults (N=322; 83 women and 239 men) entering alternative to incarceration programs in New York City. Researchers collected data through structured interviews including information on sociodemographics, substance use, prior incarcerations, and barriers that had prevented a participant from visiting or returning to a service provider. Less than half of the participants had earned a high school diploma or GED. When analyzing collapsed data for male and female participants, they found that a greater number of prior incarcerations were significantly associated with a greater number of barriers that prevented accessing a service provider. When they analyzed the data disaggregated by sex and controlling

for sociodemographic and substance use indicators, researchers found that the relationship between a greater number of prior incarcerations and greater number of service barriers experienced remained significant only for men.

31. Esposito Michael, Lee Hedwig, Hicken Margaret, et al. The Consequences of Contact with the Criminal Justice System for Health in the Transition to Adulthood. *Longit Life Course Stud.* 2017;8(1):57-74.

Esposito et al. examine the association between incarceration and health in the United States during the transition to adulthood. They applied the Bayesian Additive Regression Trees (BART) to data from The National Longitudinal Study of Adolescent to Adult Health dataset (n=10,785) to model incarceration's effect on health controlling for confounding variables (93 variables, and 36 covariates categorized as: demographic characteristics, prior health status behaviors, engagement in risky behavior, social connectedness, disposition characteristics, parental characteristics, and contextual residential characteristics). Authors examined three health outcomes: 1) an indicator for cardiovascular health (i.e. hypertension or raised blood pressure), 2) a measure of general health status (i.e., excellent/very good self-reported status), and 3) a measure of mental health status (i.e., depression). The analysis of two separate samples found individuals who had been incarcerated were more likely to suffer from depression, less likely to report being in excellent or very good health, and more likely to have hypertension than their peers with no history of incarceration. To examine if the health inequalities between previously incarcerated and never incarcerated individuals was a product of incarceration rather than a product of features that occurred prior to incarceration, they used the BART methodology to estimate how different the health of individuals who had experienced incarceration would be had they actually never experienced incarceration. Results suggest that elevated risk of depression among incarcerated individuals is largely a consequence of their incarceration (~5% both before and after accounting for confounders). Similarly, a prior history of incarceration appears to decrease the probability of reporting excellent/very good health (~10%), roughly half of the decrease in probability before accounting for confounders. Results show no adverse effects of incarceration on hypertension.

32. Massoglia M., Pridemore W.A. Incarceration and Health. *Annual Reviews of Sociology.* 2015;41:291-310.

Massoglia and Pridemore conducted a review of literature to evaluate the impact of incarceration on a range of health outcomes, including chronic health conditions and mortality, for individuals who are incarcerated, family members, and communities. Specific to length of incarceration, the authors cite previous research suggesting that “the impact of the length of incarceration on health appears to be less important than the fact of incarceration itself.” As part of their agenda for future research, the authors state that more research should be done related to the “different types and lengths of correctional confinement.”

33. Murray J, Farrington DP, Sekol I. Children's antisocial behavior, mental health, drug use, and educational performance after parental incarceration: A systematic review and meta-analysis. *Psychological Bulletin.* 2012;138(2):175-210.

Murray et al. conducted a systematic review and meta-analysis of the literature on parental incarceration and impacts on children's later mental, emotional, and social health. They identified 40 studies that met their strict inclusion criteria. The researchers pooled the odds ratios

across all samples in order to determine if children with incarcerated parents had a greater risk of each outcome than children in the control group who did not have an incarcerated parent or parents. These pooled odds ratios indicated that parental incarceration was significantly associated with antisocial behavior among their children even after controlling for covariates. In some subpopulations parental incarceration was significantly associated with children's poor academic performance, poor mental health, and drug use, but this association was not significant for every subpopulation and did not always remain significant after controlling for covariates.

34. Swisher RR, Roettger ME. Father's incarceration and youth delinquency and depression: Examining differences by race and ethnicity. *Journal of Research on Adolescence*. 2012;22(4):597-603.

Swisher and Roettger analyzed data from the in-home portion of the National Longitudinal Study of Adolescent Health. Due to insufficient sample size for other racial/ethnic groups, only white, black, and Hispanic respondents were included in this study. The researchers found that among all racial/ethnic groups father's incarceration is associated with increased depression and delinquency for the children, even after controlling for other variables such as demographics and family background measures. In addition, when considering these results by race/ethnicity, the data indicate that among Hispanic respondents, having their father incarcerated is associated with a higher propensity for delinquency than among white and black respondents.

35. Public Hearing: SB 5413 - Concerning solitary confinement. (Remote testimony.). *Senate Human Services, Reentry & Rehabilitation Committee*. 2021 Regular Session ed. Olympia, WA2021.

On February 9, 2021, the Senate Human Services, Reentry & Rehabilitation Committee held a hearing on Senate Bill 5413, Concerning solitary confinement (Companion legislation: House Bill 1312).

36. Turney Kristin. Stress Proliferation across Generations? Examining the Relationship between Parental Incarceration and Childhood Health. *Journal of Health and Social Behavior*. 2014;55(3):302-319.

Turney conducted a multivariate analysis that incorporates children into the stress process paradigm to examine the relationship between parental incarceration and children's health. The author used data collected through the 2011-2012 National Survey of Children's Health (NSCH), a cross-sectional probability sample of non-institutionalized children ages 0-17 years in the U.S. Adjusted for demographic, socioeconomic, and familial characteristics, the analyses show parental incarceration is independently associated with 5 of 19 health conditions considered: learning disabilities, Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder, behavioral or conduct problems, developmental delays, and speech or language problems. Results suggest parental incarceration is more detrimental to behavioral or conduct problems and developmental delays than parental divorce or separations. Findings add to the literature that children's health disadvantages may be an unintended consequence of mass incarceration. In addition, household member mental health problems are associated with 15 of 19 indicators of children's health. The use of a cross-sectional dataset made it impossible to determine whether the association is due to shared genetics, shared environments, or some combination of the two. Further research is needed to determine how mental health, incarceration, and children's mental health are associated.

37. **Henning K. The Reasonable Black Child: Race, Adolescence, and the Fourth Amendment. *American University Law Review*. 2018;67(5):1513-1576.**

In this law review, Henning presented arguments that the juvenile court system should modify the standard of "reasonable juvenile" that determines when law enforcement are justified to arrest youth under Fourth Amendment jurisprudence (search and seizure doctrine). The author argues that racial inequities in the criminal legal system, implicit racial bias, adolescent brain development, and current relationships between youth and law enforcement requires changes in the "reasonable juvenile" standard. They argue that there is a unique interplay between race and adolescence and that "race and age affect every critical decision in the Fourth Amendment inquiry." The article examines, "To what extent does the child's race affect the objective assessment of whether a police-youth encounter ventures from a 'contact' to a seizure? To what extent does the child's race affect the voluntariness of consent? To what extent should the child's race affect the officer's interpretation of a child's behavior in the reasonable articulate suspicion or probable cause analysis?" The article summarizes research and court case law for each of these sections.

38. **Special Commitment Center. 2021; Available at: <https://www.dshs.wa.gov/bha/special-commitment-center>. Accessed 5/10/2021.**

The Special Commitment Center is a total confinement facility for individuals convicted of violent sexual offenses. It is operated by the Department of Social and Health Services on McNeil Island.

39. **Corrections Washington State Department of. Restrictive Housing Fact Sheet. In: Corrections WSDo, ed. August 2021 ed. Tumwater, WA2021.**

This DOC Restrictive Housing Data Report provides trend data (January 1, 2016 to July 31, 2021) for the weekly Average Daily Population (ADP) held in MAX Custody as well as the average length of stay among the population exiting MAX Custody. DOC data show, a "[r]oughly 25% decrease in weekly ADP in Maximum Custody between January 2018 and January 2019" and a "[r]oughly 20% decrease in weekly ADP in Maximum Custody in first half of 2021." Between January 2016 and July 31, 2021, 93% (n=2,402) of those held in MAX Custody spent fewer than 500 days there and 7% (n=187) spent 500 days or more in MAX Custody. DOC reported that the downward trend in average time held in MAX Custody for the 93% of people held in MAX Custody that started in the first half of 2018 was likely disrupted by the COVID-19 pandemic. In January 2018, people were held in MAX Custody for an average of 260 days compared to the average 221 days in January 2020. The data report also provided a Restrictive Housing population snapshot on July 31, 2021. On that date, the Ad Seg population (N=497) included 261 (53%) non-Hispanic white, 75 (15%) non-Hispanic Black, 37 (7%) American Indian or Alaska Native, 5 (1%) non-Hispanic Pacific Islander, 2 (<1%) non-Hispanic Asian, and 2 (<1%) non-Hispanic other race people who were incarcerated as well as 115 (23%) individuals of Hispanic ethnicity. Meanwhile, the MAX Custody population (N=219) included 111 (51%) non-Hispanic white, 32 (15%) non-Hispanic Black, 11 (5%) American Indian or Alaska Native, 3 (1%) non-Hispanic Pacific Islander, 8 (4%) non-Hispanic Asian, and 3 (1%) non-Hispanic other race people, as well as 50 (23%) people of Hispanic ethnicity. The Hispanic population was disproportionately overrepresented in both Ad Seg and MAX Custody compared to their portion of the general prison population (16%; 2,179 people). In regards to Security

Threat Group (STG) Status, those who DOC classified as Members, Suspects, and Affiliates were two times more likely than the general population to be held in Ad Seg and three times more likely to be held in MAX Custody. "Those identified as [STG] members held a significantly larger share of the STG population in [MAX] Custody population (47%) than in the general population (34%)." As of July 31, 2021, STG Groups represented among the MAX Custody population included Sureños (29%), White Supremacists (20%), Norteños (21%), Crips (12%), Bloods (4%), Black Gangster Disciples (4%), and Other (9%). Members, suspects, and affiliates of "Norteños were nearly two times more likely to be [held in] MAX Custody than other STG groups."

40. **About | Prison Rape Elimination Act. 2021; Available at: <https://www.prearesourcecenter.org/about/prison-rape-elimination-act>. Accessed May 17, 2021.**

This PREA Resource Center webpage provides an overview of the Prison Rape Elimination Act (PREA), which was passed in 2003. Among other provisions, the act "created the National Prison Rape Elimination Commission and charged it with drafting standards for eliminating prison rape." The Department of Justice reviewed recommended standards and passed and published them in final rule in the Federal Register on June 20, 2012. The PREA Standards went into effect August 20, 2012. The National PREA Resource Center provides federally funded training and technical assistance to states and localities to come into compliance with these federal standards.

41. **Corrections Washington State Department of. DOC 320.200 Administrative Segregation. In: Corrections WSDo, ed. 6 March 2020 ed. Olympia, WA2020.**

The Washington State Department of Corrections revised DOC policy 320.200 governing the use of administrative segregation (March 6, 2020). According to DOC's summary, the revised policy included "major changes." For example, certain behaviors which alone could previously resulted in placement in administrative segregation are no longer considered significant risk under normal circumstances (e.g., tattooing, horseplay, possession of a cell phone, interfering with count).

42. **James K. , Vanko E. The Impacts of Solitary Confinement. Brooklyn, New York: Vera Institute of Justice; 2021.**

This issue brief from the Vera Institute of Justice summarizes current evidence on the impacts of solitary confinement on the psychological, neurological, and physiological health of individuals who are incarcerated. "Numerous studies have also found that solitary has a disproportionate impact on Black and brown people, youth, and people with mental illness," who are disproportionately held in solitary confinement. Additionally, those with preexisting mental health conditions and young or emerging adults (ages 18 to 25 years) are particularly vulnerable to the harmful effects of solitary confinement. It also discusses the stressful conditions that custody officers work in (generally). Authors evidence studies that have shown "corrections officers suffer from heart disease, hypertension, PTSD, and suicide at especially high rates, even compared with people with similarly stressful jobs, such as military veterans or police officers." Authors also highlight the need for further research to understand how working conditions specific to solitary confinement units impact corrections staff. In addition to the effects on those held in solitary confinement and staff working in these units, families of people held in solitary confinement while incarcerated are also negatively affected. Moreover, "most studies examining

the effects of solitary find that it *does not* decrease instances of misconduct or violence—including assaults on corrections staff or other incarcerated people—and therefore does not improve prison and jail safety." Additionally, "research suggests that time spent in solitary may actually increase people's likelihood of post-release offending, especially violent re-offending. And people released directly from solitary into the community have significantly greater recidivism rates." Authors also discuss the economic costs of holding someone in solitary confinement. Finally, evidence shows that solitary confinement disproportionately impacts certain populations. "Mirroring inequalities often seen throughout the criminal legal system, some people are more likely than others to end up in solitary confinement based on their race, gender identity, sexual orientation, age, physical and mental disabilities, or other characteristics. These disparities may be compounded when an incarcerated person falls into more than one disadvantaged demographic group."

43. **O'Keefe M.L., Klebe K.J., Stucker A., et al. One Year Longitudinal Study of the Psychological Effects of Administrative Segregation. State of Colorado Department of Corrections and University of Colorado, Colorado Springs; 2011.**

O'Keefe et al. stated that, "critics have argued that the conditions of [administrative segregation] confinement exacerbate symptoms of mental illness and create mental illness where none previously existed. Empirical research has had little to offer this debate; the scant empirical research conducted to date suffers from research bias and serious methodological flaws." They noted that individuals who are incarcerated have rates of serious mental illness three times higher than individuals who are not incarcerated. Individuals held in solitary confinement have rates of serious mental illness 50% higher than the rate in the general prison population. However, research has not shown whether "these high rates of mental illness are caused by [administrative segregation] relative to the general prison population or whether there is a selection bias such that [individuals] with mental illness, unable to adapt to general prison settings, are placed in [administrative segregation] at higher rates." The authors conducted a longitudinal study with 247 males who were incarcerated in the general population and in solitary confinement in the Colorado prison system to determine the long-term impacts of solitary confinement on eight psychological symptoms (i.e. anxiety, cognitive impairment, depression-hopelessness, hostility-anger control, hypersensitivity, psychosis, somatization, withdrawal-alienation). The study sought to determine which psychological domains were impacted by solitary confinement, whether individuals with mental illness experienced worse outcomes than individuals without mental illness, and to compare outcomes with the general prison population. Individuals were tested six times: pre-baseline (as close to the administrative segregation hearing as possible), baseline (when individuals were moved to the Colorado State Penitentiary, a long-term segregation facility), and at 3, 6, 9, and 12 months after baseline. They stated, "the results of this study are largely inconsistent with our hypotheses and the bulk of literature that indicates [administrative segregation] is extremely detrimental to inmates with and without mental illness." The comparison group consisted of individuals who had been placed in administrative segregation and released back to the general population following their administrative segregation hearing. The authors noted that these individuals were "assumed to be as similar as possible to [individuals held in administrative segregation]." However, individuals were held an average 30 days in solitary confinement prior to their administrative segregation hearing. More current research has suggested that any amount of time held in solitary confinement may cause psychological distress. While other research has shown that psychological distress of individuals

held in solitary confinement may decrease after return to the general population, it is possible that individuals who experienced solitary confinement and were released back to the general population still experienced high levels psychological distress, which could skew the study results. The authors also found that individuals with mental illness experienced greater distress than individuals without mental illness, regardless of where they were housed. The authors found that individuals with severe mental illness experienced the greatest psychological distress regardless of where they were housed and individuals held in the psychiatric care facility “had the greatest degree of psychological disturbances and the greatest amount of negative change.” Overall, “although the differences were small, the [individuals] with serious mental illness are less likely to improve in segregation and are less likely to get worse compared to mentally ill [individuals in the general prison population].” The authors state that findings may not be generalizable to other prison systems.

44. **O’Keefe M.L., Klebe K.J., Metzner J., et al. The context and clarification of a single study: Response to commentaries on *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*. *Corrections & Mental Health*. No date.**

O’Keefe et al. responded to critiques from other authors about O’Keefe 2010. Among their responses, they provided additional context related to the comparison group. They stated, “we recognized that this early placement in segregation conditions might impact the psychological well-being of participants...participants were confined in segregation for an average of 30 days prior to the first assessment.” They stated that previous research and the study’s advisory board “did not believe that the short confinement in segregation that comparison subjects might experience at the start of the study would be detrimental to the design.” They also reported that 35% of individuals who were held in administrative segregation during the study period had previously been held in solitary confinement (compared to 25% of individuals who were released back to the general population after the administrative segregation hearing). They stated that “there was not a single outcome variable in which previous [administrative segregation] experience was statistically significant nor had an effect size that explained a meaningful amount of variance.”

45. **Shalev S., Lloyd M. Though this be method, yet there is madness in't: Commentary on *One Year Longitudinal Study of the Psychological Effects of Administrative Segregation*. *Corrections & Mental Health*. No date.**

Shalev and Lloyd authored a response to O’Keefe 2010. They stated that “many factors contribute to how [individuals] experience their confinement and how they are affected by it, including: the physical conditions of confinement; level and form of contact with the outside world; in-cell provisions; access to programs and activities; medical and mental health treatment; staff-prisoner relationships; and the ethos and atmosphere in the prison. These factors will all impact on the [individual’s] experience of solitary confinement, making it near impossible to control for all potential variables and limiting the ability to generalize any findings.” Shalev and Lloyd offered critique of the O’Keefe 2013 study: 1) potentially confounding circumstance occurring in the Colorado prison system during the study period (e.g. filming for a National Geographic documentary; budgetary negotiations to build additional administrative segregation units); 2) reliance on self-report data (e.g. high levels of inconsistency across scales); 3) concerns with study groups and design (e.g. all individuals, including individuals in the comparison group had experienced solitary confinement; individuals with learning difficulties or less than 8th grade

reading level were excluded resulting in a sample with a higher education; access to “privileges” was not controlled for); 4) lack of long-term impact after release to community; and 5) statistical analyses (e.g. comparing mean scores over time increases threat of regression to the mean).

46. Cloud D. H., Ahalt C., Augustine D., et al. Medical Isolation and Solitary Confinement: Balancing Health and Humanity in US Jails and Prisons During COVID-19. *J Gen Intern Med.* 2020;35(9):2738-2742.

During the 2019 Coronavirus (COVID-19) pandemic, jails and prisons have experienced high rates of COVID-19 cases and transmission. Cloud et al. provided an overview of COVID-19 and medical isolation in jails and prisons. They provide some policy and procedural recommendations to differentiate quarantine/medical isolation from solitary confinement. The authors noted that, “in many correctional facilities, the only available spaces for implementing quarantine or medical isolation are those typically used for punishing people with solitary confinement...Repurposing solitary confinement units for medical purposes, however, runs the risk of corrections officers falling back on policies that subject people to living conditions known to harm their health. They explained, “use of isolation to curb transmission of COVID-19 in correctional facilities will complicate the emerging crisis, as incarcerated people become reluctant to report symptoms for fear of being moved to solitary confinement, those who do report symptoms will be forced to endure an experience known to cause psychological and physical harm, and system-wide unrest will be triggered in institutions where fears about being placed in medical isolation could run rampant. Yet, quarantine and medical isolation in response to COVID-19 are necessary to halt the spread of infection; without them, containment of disease transmission will be exceedingly difficult if not impossible, posing significant health risks to incarcerated people, correctional healthcare providers, security staff, and the families and communities to which workers return at the end of each shift.” Moreover, “the use of punitive isolation during the COVID-19 epidemic- including indeterminate system-wide facility lockdowns where people cannot communicate with their families, exercise outside, participate in programming, or interact with healthcare professional- will deter people from reporting symptoms, in turn threatening the health of all those who work in jails and prisons.”

47. Wildeman Christopher, Andersen Lars H. Solitary confinement placement and post-release mortality risk among formerly incarcerated individuals: a population-based study. *The Lancet Public Health.* 2020;5(2):e107-e113.

This study by Wildeman and Andersen assessed the relationship between placement in solitary confinement and mortality in the five years following release among formerly incarcerated individuals. The study used data from the Danish Prison and Probation Service to estimate the association between being placed in solitary confinement and mortality (death and cause of death) among formerly incarcerated Danish individuals (compared to those who had not experienced solitary confinement during their incarceration). Researchers controlled for prison security level, release year, sentence length, reason for conviction, age of admission, sex, ethnic minority background, and education level. The study population included 13,776 individuals with 812,374 person-months of exposure to risk of mortality (through December 31, 2016). Deaths recorded by the Danish Board of Health Data were categorized as any cause death (all mortality), non-natural causes of death (i.e., accidents, self-harm, and violence), and natural causes of death (i.e., inverse of non-natural deaths). Of those who spent time in solitary confinement (i.e., disciplinary or administrative segregation; n=1,662), 25.9% spent fewer than

72 hours (total) in solitary confinement during their incarceration, 42.8% spent between 72 hours and 1 week in solitary confinement, and 31.2% spent more than 1 week in solitary confinement (median 5.0 days [IQR 3.0–10.0], mean 8.7 days [SD 13.2]). "Individuals who spent time in solitary confinement had longer average sentence lengths, were younger at admission, were convicted for violent crimes at a higher proportion, identified with ethnic minority backgrounds, did not acquire education beyond basic schooling, and served their sentences in a high-security facility." Results showed "Formerly incarcerated Danish individuals who spent time in solitary confinement had higher overall mortality 5 years after release (4.5%) than did those who had not spent time in solitary confinement (2.8%; $p < 0.0001$). After adjusting for possible confounders, our results suggested an association between solitary confinement and elevated mortality due to non-natural causes (hazard ratio 2.342, 95% CI 1.527–3.592). [Researchers] did not identify a significant association with natural causes." Specifically, "After 13 months the difference for any cause of death was statistically significant (1.3% solitary and 0.8% non-solitary, $p = 0.0492$) and the difference for non-natural causes was statistically significant after 21 months (1.5% solitary and 0.9% non solitary, $p = 0.0390$)." Causes of death were "consistent with those that lead to excess mortality among formerly incarcerated individuals in the USA and Europe." Moreover, "the 5-year mortality among formerly incarcerated individuals who were placed in solitary confinement was almost ten times that in the general population (with similar sex and age composition)." Overall, the study showed that "short periods in solitary confinement were linked to elevated post-release mortality and that these elevated mortality rates were confined to non-natural causes."

48. Butler H.D., Steiner B., Makarios M.D., et al. An Examination of the Influence of Exposure to Disciplinary Segregation on Recidivism. *Crime & Delinquency*. 2020;66(4):485-512.

Butler et al. conducted a study with individuals in Ohio to determine the impact of solitary confinement on recidivism (i.e., rearrest within 1 year of release, felony rearrest within 1 year of release, reincarceration within 7 years of release, and reincarceration for a new crime within 7 years of release). Specifically, the authors evaluated whether individuals who experienced disciplinary segregation were at greater odds of recidivism post-release. They evaluated three main independent variables: placement in solitary confinement, number of times placed in solitary confinement, and total number of days held in solitary confinement. They noted that individuals "confined in [solitary confinement] were young, male, Black, unmarried, and lacked education. Similarly, [people] with these characteristics also have increased odds of recidivism." Individuals "who have extensive criminal records, serious commitment offenses, and greater criminogenic needs (e.g., referrals for programming) and who affiliate with gangs are most likely to be confined in [solitary confinement] and most likely to recidivate upon their release." The authors hypothesized that "disciplinary segregation may influence [people's] odds of recidivism in several ways, such as via deterrence, labeling, or by worsening their mental state." The authors also noted that individuals held in solitary confinement often lack access to programming, some of which is known to lower the risk of recidivism after release to community (e.g., cognitive behavioral programs). Overall, they concluded that solitary confinement was associated with increased odds of recidivism. They found that exposure to solitary confinement, number of placements, and days served were all associated with increased odds of reincarceration within 7 years. For measures of recidivism, the authors found that, solitary confinement "has the largest magnitude in effect on return to prison within 7 years...and return to prison for a new crime

within 7 years. Increases in the predicted probability of return to prison within 7 years (and for a new crime) range from 13-20% for returning to prison and 11-17% for returning to prison for a new crime." They also found that individuals who experienced solitary confinement within 6 months prior to release had higher mean levels of recidivism than those who were segregated earlier in their sentence.

49. **Sugie Naomi F., Turney Kristin. Beyond Incarceration: Criminal Justice Contact and Mental Health. *American Sociological Review*. 2017;82(4):719-743.**

The authors examined associations between criminal justice contact and mental health using data from the National Longitudinal Survey of Youth (NLSY97). The nationally representative survey of a contemporary cohort includes information about criminal justice contact (including arrest, conviction, and incarceration) and mental health over time. Analysis showed arrest and incarceration—but not conviction—are independently associated with poor mental health. Arrests accounted for nearly half of the association between incarceration and mental health. Authors propose uncertainty and anticipatory stress are primary mechanisms that worsen mental health and deserve further study. Researchers document that criminal justice contact is socially patterned and is more common among non-Hispanic Blacks than non-Hispanic whites and Hispanics. However, the associations between criminal justice contact and mental health are similar across racial/ethnic groups. Researchers found respondents' previous exposure to disadvantaged ecological contexts (i.e., counties with high proportions of residents with incomes below the poverty, unemployed civilians, female-headed households, and households receiving public assistance income) had negative consequences for mental health. The authors assert the importance of mental health for other life course outcomes (e.g., physical health, socioeconomic status, children's wellbeing) and conclude that the consequences of criminal justice contact may extend beyond mental health and have broad intra- and inter-generational consequences.

50. **Natapoff Alexandra. Misdemeanor Decriminalization. *Vanderbilt Law Review*. 2015;68(4):63.**

This law review found that full decriminalization, defined as reclassification of misdemeanors as civil infractions, of non-violent offences may reduce arrests, days of incarceration, and fines associated with offenses like driving while license suspended in the third degree (DWLS 3). However, Natapoff noted outcomes may vary dependent on how local jurisdictions apply the provisions. Defendants with the resources to pay fines can terminate contact with criminal justice system quickly and without the lasting effects of a criminal record. However, because Washington State incarcerates defendants for failure to pay fines, a fine-only model may translate into jail time for indigent individuals through the use of contempt proceedings (pay or appear). Incarceration due to failure to appear may exacerbate disparities in incarceration rates by disproportionately affecting people with low-incomes and people of color who may be less likely to find the time and transportation required to appear than offenders with more time and resources. Failure to pay may also negatively impact an individual's credit rating and their ability to rent an apartment, buy a car, or secure employment. An individual's records (arrest and criminal) and/or inability to reinstate their driver's license may also negatively affect employment (current and future prospects). Jurisdictional use of citations to measure performance or fines to fund the criminal justice systems and general budgets could exacerbate disparities by further racializing enforcement and serving as a regressive tax.

51. Yi Youngmin, Turney Kristin, Wildeman Christopher. Mental Health Among Jail and Prison Inmates. *American Journal of Men's Health*. 2017;11(4):900-910.

Yi et al. analyzed a sample (n = 3,139) from the Fragile Families and Child Wellbeing Study (FFCWS), a longitudinal survey commonly used to study the individual and spillover consequences of incarceration, to assess how the relationship between current incarceration and self-reported mental health varies across jail incarceration and prison incarceration. Researchers found fathers incarcerated in jails "...have higher odds of depression (OR=5.06), life dissatisfaction (OR = 3.59), and recent illicit drug use (OR=4.03)" compared to those not incarcerated. While fathers incarcerated in prisons "...have higher odds of life dissatisfaction (OR=3.88) and lower odds of heavy drinking (OR=0.32) compared with those not incarcerated." Results confirm the negative associations between incarceration and mental health and provide new insight into between-facility differences in mental health of currently incarcerated fathers. Authors conclude that further research is needed to better understand the effects of incarceration in jails and the implications for the well-being of current and former inmates' children and families.

52. Management Washington State Office of Financial. Multiple Agency Fiscal Note Summary: HB 1312, Solitary confinement. 2021.

Washington State Departments of Children, Youth, and Families; Corrections; and Social and Health Services as well as the Criminal Justice Training Commission submitted fiscal notes for HB 1312, Concerning solitary confinement. Local government courts, school districts, and governments also submitted fiscal analyses.

53. Braun C., Peterson L., Scalzi G. Analytics and Aligning Treatment and Custody Staff Reduces Restrictive Housing Rates. North Dakota: North Dakota Corrections and Rehabilitation.

This presentation from the North Dakota Department of Corrections and Rehabilitation provides an overview of the department's Behavioral Intervention Unit (BIU), which it created in 2015 to replace its traditional and expanded Administrative Segregation (Ad Seg) Units. In 2013, the department had increased the capacity of its maximum-security facility by 40% (adding 48 beds). In less than 18 months, the Ad Seg population had risen from 50 to 105 individuals, with bed days per month rising from 1700 to more than 2900. The department reassessed its use of the unit and found they were over utilizing the unit (e.g., used as a response to annoying behaviors). Staff realigned the unit mission by redefining admit criteria and goals. For example, the decided that people would only be moved out of the general population when risk to others or disruption of orderly operations of the institution became to great. "When a resident's behavior makes them truly unsafe in general population [e.g., assault and battery of staff, arson, sexual assault], we separate, assess and equip. This process involves an integrated team of security and treatment staff from start to finish." While the number of officers staffing the BIU unit is the same as the former Ad Seg unit, the number of individuals housed in BIU is just 19% of the previous Ad Seg population. "The other 81% of the population previously isolated in [Ad Seg] are still in the prison system, but they are handled safely in the general population or in the residential mental health facility." Data show that "focusing more staff on fewer residents DID NOT cause increased violence across the facility" during the same period that the total prison population increased by roughly 200 people. When an individual is referred to BIU, an initial assessment is used to determine if BIU placement is necessary for the safety of others, and whether the risk

behavior can be addressed in another way. "For example, when a resident had smuggled in a controlled substance through a visitor, [staff] restricted that person's visiting to just video visitations for a period of time and made an expedited referral to substance use programming as an alternative to BIU placement." For those who are placed in BIU, behavioral health staff make a recommendation about the type and intensity of services needed. Those who are willing to participate in the standard BIU program, including skills practice with staff and three group sessions per week, are referred as such. "Those who are not motivated to participate or who are continuing to display harmful or risk behaviors within the BIU may be referred for more intensive individualized interventions to include a more specific behavior management plan and individual therapy." The guiding question in BIU is "What does this person need to do in order for us to determine that he is safe to return to general population housing?" Based on this, the team determines target behaviors and cognitive and behavioral skills that they need to learn and practice in order to effectively display those prosocial behaviors. Rather than relying on the absence of negative behavior during their stay in restrictive housing, where there isn't much opportunity to do so, staff also require the presence of positive behavior in order to be ready to return to general population. The goal is 'progress not perfection'. Collectively, staff and individuals address the highest risk or most harmful behaviors first, and they must be generally safe before returning to a lower level of care. The three group sessions per week focus on motivation, goal-setting, cognitive restructuring, social and emotional regulation skills, problem-solving, and skills practice and generalization. If residents attend group sessions, then they may also attend one extra hour of outside recreation time per day. They are also offered at least two structured group recreation activities with a staff member each week as well as classes (e.g., creative writing). Outside of structured sessions, corrections staff are asked to engage with each resident at least once per shift to practice the individual resident's focus skill and to have some friendly conversation throughout their rounds with all residents. The goal is to help residents shift from avoiding interaction as a way to avoid conflict to pro-active interaction as a way of avoiding conflict, by building rapport and mutual respect/empathy. Department staff also implemented explicit verbal and tangible reinforcements. For example, staff are asked to praise residents when they see them implementing a specific behavior and to share why it was appreciated. They also offer numerous options for tangible reinforcement, including extra recreation time, extra phone time, access to property items the person has purchased, access to commissary items the department has purchased (e.g., snacks, coloring book pages, stamps, hygiene items). Across the prison, positive behavior reports recognizing achievements are placed into a weekly drawing. The winner gets \$5 toward their spending account. While staff were initially pushed back on the idea of incentives, evidence shows that it is working. For example, one resident shared, "At first I just did it because I wanted to get the privileges, but then I learned that my life was better overall, so I continued to do it." That shift from extrinsic to intrinsic motivation works well as once a skill becomes a regular behavior staff no longer need to reward that behavior. As a resident works to demonstrate their readiness to move back to general population, they are transferred to the Administrative Transition Unit (ATU) where they can demonstrate newly acquired skills. "They still spend most of their day within the unit, but move about...without restraints and interact with one another in smaller, less stressful settings. [Staff] continue to monitor progress and pull people back into the more restrictive levels as necessary." While in ATU, residents also eat one meal per day in the general population dining room and attend one recreation time with general population residents. Data show that the approach is working. The rate of admission has decreased to 14% of the previous rate under the expanded Ad

Seg approach. Readmission has also decreased from 42.3% under the 26 months of expanded Ad Seg model (336 individuals) to 20.4% under the 27 months of BIU programming (23 individuals). The department is also looking to see if they can predict the need for BIU placement based on 6 indicators (i.e., age, sentence length, violent offense, gang affiliation, mental illness, and custody rating) in order to pre-emptively provide supports to individuals.

54. Reiter K. Law's Infamy: *Ashker v. Governor of California* and the Failures of Solitary Confinement Reform. Advance copy ahead of publication.

This chapter was provided to the HIR Team by Dr. Reiter ahead of release. In this chapter, Dr. Reiter examines the class action lawsuit, *Ashker v. Governor of California*, filed on behalf of 500 prisoners in California who had each been housed in solitary confinement for ten years or more, and its effect on the use of solitary confinement in California. The case was settled August 31, 2015, and the agreement stated the department would eliminate solitary confinement for periods of more than five years and guaranteed that those 500 class members confined continuously in solitary for at least ten years the opportunity to live in the general population. Reiter also examined how the persistence and the mechanisms allowing solitary confinement might reveal possibilities for reform.

55. Pope L. Racial Disparities in Mental Health and Criminal Justice. Vol 2021: National Alliance on Mental Illness (NAMI) Blog; 2019.

This National Alliance on Mental Illness Blog post discusses racial inequities in mental health that are perpetuated by the criminal legal system.

56. Bronson J., Berzofsky M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. Special Report. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2017.

This Bureau of Justice Statistics (BJS) Special Report presented data on mental health indicators for people held in U.S. prisons and jails in 2011-2012. BJS reported that 14% of people held in state and federal prisons meet the threshold for serious psychological distress (compared to 5% of the general U.S. population) and 37% have been told in the past by a mental health professional that they had a mental health disorder. About 36% of people with serious psychological distress were being treated. However, there are inequities by race/ethnicity and whites were more likely than Black or Hispanic individuals to meet the threshold for serious psychological distress. Whites were also more likely to have been told they had a mental health disorder compared to Blacks. In addition, people "who met the threshold for [serious psychological distress] were more likely than those without [serious psychological distress] to be written up or charged with an assault while incarcerated" compared to people without a mental health problem.

57. Safe Alternatives to Segregation: Promising Practices. 2021; Available at: http://safealternativestosegregation.vera.org/promising-practices/?pp_keyword&taxes%5Bpp_facility_type%5D%5Bstate-prison%5D=on. Accessed 7/6/2021.

Vera has compiled a list of 24 promising practices and safe alternatives to reduce the use of solitary confinement based on strategies that have been implemented in state prison systems. Promising practices include reforms related to housing and segregation options; conditions of

confinement; accountability and transparency; entry criteria and admissions; exit criteria and strategies; and staff training.

58. Vanko E. Step-down Programs and Transitional Units: A Strategy to End Long-term Restrictive Housing. Vera Institute of Justice; 2019.

In this policy brief, Vera provided information about transitional units and step-down programs as alternative housing options to reduce the use of solitary confinement. In 2017, 27 state prison systems reported having transitional units and/or step-down programs that serve as less-restrictive housing options between solitary confinement and the general prison population. Vera noted that, "transitional units or programs can serve as a way to move people out of restrictive housing and into a less-restrictive environment as quickly as possible while still maintaining safety. In addition, such units can provide programming and treatment to address any unmet needs (such as mental health needs) and promote positive behavioral change, and can allow meaningful socialization and group activity to help people become reaccustomed to being around others." They listed five key elements of successful transition and step-down units: 1) Make individualized decisions about whether or not someone should be placed in a transitional or step-down unit; 2) Ensure conditions of confinement in a transitional or step-down unit are significantly different and progressively less restrictive than conditions of solitary confinement; 3) Address needs/behaviors by providing meaningful programming, education, mental health treatment, and other activities; 4) Articulate a clear, individualized pathway and progression for return to the general population; and 5) Transition an individual to the appropriate general population placement. They noted two common pitfalls to transitional units or step-down programs. First, programs must include clear pathways and progressions so that individuals do not get stuck at one phase or constantly get demoted back to the beginning phase in case of violations. Similarly, programs must be structured so that individuals do not experience a "revolving door" between the general population and solitary confinement by providing effective programming, progressively less restrictive conditions, and appropriate general population placement. Second, staff should receive adequate training and resources to support this work. Vera noted, "systems must also promote the culture change necessary to implement an effective program, using communication, training, and reinforcement." Similarly, transitional units and step-down programs must have adequate physical space and staffing.

59. AMEND: Changing Correctional Culture. 2021; Available at: <https://amend.us/>. Accessed 7/8/2021.

This webpage provides an overview of the AMEND research group at University of California San Francisco.

60. Webb EV, Glosser R. . Transgender, Intersex, and Gender Non-Conforming Systematic Review. Olympia, WA: Office of the Corrections Ombuds; 8/13/2021 2021.

This report from the Washington State Office of the Corrections Ombuds (OCO) summarizes issues shared by transgender, intersex, Two-Spirit, non-binary, and gender diverse prisoners, as reported to OCO from 2019 through early 2021. It includes case examples from more than 35 gender diverse people incarcerated at eight Washington State prison facilities. The final report also includes a response from the Department of Corrections (DOC) regarding the agencies efforts to better meet the needs of those gender diverse people in its custody (e.g., policy

changes, staff training). For example, "within the past 18 months, [DOC] transferred the first trans woman from a men's facility to WCCW."

61. Dellazizzo L., Luigi M., Giguere C. E., et al. Is mental illness associated with placement into solitary confinement in correctional settings? A systematic review and meta-analysis. *Int J Ment Health Nurs.* 2020;29(4):576-589.

This meta-analysis by Dellazizzo et al. examined "the association between any mental health problem and the risk of being placed into solitary confinement in correctional settings." Literature searches were conducted of databases (i.e., PubMed, PsycINFO, Web of Science and Google Scholar) from inception date to November 2019. Study inclusion criteria included adults (i.e., older than 18) held in correctional settings (i.e., jail, prison, remand); any indication of a potential mental health disorder measured before placement into solitary confinement; a control group of persons incarcerated but not placed into solitary confinement (i.e., general correctional population); statistical associations able to be calculated using odds ratios (OR); and a retrospective, cross-sectional, or longitudinal study design. The meta-analysis was performed using random-effects models. Authors screened 2,777 potential studies and 11 studies met inclusion criteria representing a total of 163,414 people experiencing incarceration. Included studies examined a mix of mental health disorders rather than a specific diagnosis. Authors reported, "[t]he odds ratio (OR) from the pooled studies was 1.62 (confidence interval (CI) = 1.21-2.15). The observed relationship remained unchanged regardless of the removal of outliers (OR = 1.63, CI = 1.47-1.80) and regardless of the adjustment of confounders (OR = 1.58, CI = 1.32-1.88)." The study showed a moderate association (defined as an OR = 1.6-2.5) between any mental health problem and placement into solitary confinement within a fairly large sample. Authors concluded, "[a]s more individuals suffering from mental illness enter the correctional system, it is essential that correction officials create new safe interventions to manage these inmates and offer them proper mental health care to limit the use of solitary confinement, which may have deleterious effects."

62. Prevention Office of Juvenile Justice and Delinquency. Disproportionate Minority Contact: Literature Review, A product of the Model Programs Guide. 2014.

The Office of Juvenile Justice and Delinquency Prevention published definitions and a summary of literature related to "Disproportionate Minority Contact" in the juvenile criminal legal system. Amendments to the Juvenile Justice and Delinquency Program Act of 1974 defined "Disproportionate Minority Contact" as "the rates of contact with the juvenile justice system among juveniles of a specific minority group that are significantly different from rates of contact for white non-Hispanic juveniles." States that receive federal funding from the Office must present data by the following race/ethnicities: white (non-Hispanic), Black and African American (non-Hispanic), Hispanic or Latinx, Asian (non-Hispanic), Native Hawaiian or other Pacific Islander (non-Hispanic), American Indian/Alaska Native (non-Hispanic), and Other/Multi-racial. They define "'minority' as youth who are American Indian/Alaska Native, Asian, Black or African American, Hispanic or Latino, or Native Hawaiian or other Pacific Islander." Disproportionality must be reported for nine points of contact, including arrest, referral to court, diversion, secure detention, charges, adjudication, probation supervision, secure confinement, and transfer to adult court. They state that youth of color are more likely to have contact with the juvenile system than white, non-Hispanic youth. There are two main theories for disproportionate contact, including differential offending/involvement (e.g., differences in youth

behavior, neighborhood factors) and differential treatment/selection (e.g., structure of criminal legal system decision-making). The report provides an overview of reasons for disproportionate contact and discusses differential opportunities available for prevention and treatment.

63. Project The Sentencing. Policy Brief: Disproportionate Minority Contact in the Juvenile Justice System. 2018.

This policy brief discusses Disproportionate Minority Contact, which "reflects both racial biases woven into the justice system ("differential selection") and differences in the actual offending patterns among [racial/ethnic] groups ("differential involvement")." Federally, juvenile justice system contact is defined as, "arrest, referral to court, diversion, secure detention, petition (i.e. charges filed), delinquent findings (i.e. guilt), probation, confinement in secure correctional facilities, and/or transfer to criminal/adult jurisdiction." The authors noted that disproportionate minority contact in the juvenile justice system is well-documented and the U.S. Justice Department has stated that juvenile disproportionate minority contact "is evident at nearly all contact points on the juvenile justice system continuum." Black youth are more likely to be arrested, referred to juvenile court, processed, sent to secure confinement, and transferred to adult facilities than white youth. Nationally, African American youth are twice as likely to be arrested than white youth. However, this disproportionality changes depending on the crime. For example, in 2011, Black youth were 269 percent more likely to be arrested for violating curfew laws than white youth. This disproportionality has also grown for some crimes (e.g. property crimes). In addition, "youth of color are overrepresented at many stages of the juvenile justice system as compared with their presence in the general population." For example, African American youth comprise 14% of the general population, but account for 40% of secure placement. The authors also present data showing that most juvenile arrests are for non-violent, low-level, or non-criminal acts. Violent crimes account for only 5% of juvenile arrests. Property crimes are the most common offenses for juveniles, and account for 25% of arrests. The authors also note the intersectionality with geography. They state that, "given the realities of residential patterns by race, [differences in arrest rates by race for the same behaviors] may be reflected in higher arrest rates of minority youth than white youth for some offenses. As a result, juveniles behaving in the same way- for example, hanging out late at night- will be treated differently based on where they live, not on how they behave." This brief also outlines how policy choices can worsen disparities, including police presence in schools and the "criminalization of misbehavior," valid court orders that lead to detention, and policies impacting population density and segregated housing.

64. Robles-Ramamurthy B., Watson C. Examining Racial Disparities in Juvenile Justice. *Journal of American Academy of Psychiatry and the Law*. 2019;47(1):48-52.

Robles-Ramamurthy and Watson provided commentary on research focusing on racial inequities in the juvenile justice system. Disproportionate minority contact and racial disparities are present at every level of processing within the juvenile justice system, including at arrest, referral, diversion, detention, filings, findings, probation, confinement, and transfer to adult court. The authors summarize data from Washington State, as well as provide discussion of theories used to explain racial disparities within the criminal justice selection. The "differential offending" theory suggests that minority youth commit crimes at greater rates than white youth. However, studies have found that "this difference would not explain the full picture of minority overrepresentation throughout the justice system." The "selection" theory suggests differential

contact. For example, the National Longitudinal Survey of Youth found that Black youth were more likely to be arrested and arrested multiple times compared to white youth. The authors also cite evidence from a systematic review of 72 studies that found differential treatment of minority youth in 82% of studies and at 9 different decision points in the juvenile justice system. They summarize that, "evidence of a race effect was greater at the earlier stages of the process, including arrest, referral to court, and placement in secure detention." Robles-Ramamurthy and Watson state that, "the intricacies of racial disparities in the juvenile justice system are difficult to study because of the close relationship between crime and many of the social factors affecting communities in which minority youth are likely to be raised." Youth of color are more likely to experience higher poverty rates and lower socioeconomic status, to attend schools with zero-tolerance policies and law enforcement presence on campus, and to experience parental incarceration due to disparities in the larger criminal justice system. The authors also summarized long-term impacts of juvenile justice contact on youth, including lower high school graduation rates, higher rates of unemployment, higher rates of eviction and homelessness, and increased rates of recidivism. Overall, the authors concluded that, "addressing social factors that are at the root of disproportionate minority contact will result in significant benefit in reducing racial disparities within the juvenile justice system."

65. Sussman N. I., Lee T.G., Hallgren K.A. Use of Manifest Injustice in the Washington State Juvenile Rehabilitation Administration. *Journal of the American Academy of Psychiatry and the Law*. 2019;47:42-47.

Sussman, Lee, and Hallgren examine the use of manifest injustice in the Washington State Juvenile Rehabilitation Administration, for youth aged 15-19 years old and in custody as of January 2016. The Washington State juvenile justice system has disproportionate minority contact for all minority groups, which is consistent with previous and national research. For example, African American youth were seven times more likely, multi-racial youth were three times more likely, and Hispanic youth were 1.5 times more likely to be in Juvenile Rehabilitation Administration custody than white youth in the state. Washington State Juvenile Code includes a "manifest injustice provision" allows judges to sentence youth outside standard sentencing guidelines. The provision states that, "if the standard sentencing guidelines yield a sentence that would be an injustice to the offender or risk the safety of the public, the judge can use [manifest injustice] to impose an alternative disposition" that results in either a shorter or longer sentencing range or in institutionalization to a residential detention facility. The authors hypothesized that judges would be more likely to use the provision to decrease sentences of white youth and to increase sentences of minority youth. The authors note that low numbers decreased the statistical power of their analyses, and required that they examine the impacts across five racial/ethnic groups: Caucasian, African American, Hispanic, multiracial, and "all minorities." Although not statistically significant, the authors found that African American youth had manifest injustice used less frequently to decrease their sentences than white youth. However, the authors also found that African American and multiracial youth were less likely to have manifest injustice used to increase their sentences than white youth (i.e. white youth were more likely to have their sentences increased or intensified than minority youth). The authors hypothesize that this is likely due to the fact that "African American youth reside in urban and liberal parts of the state where judges may be more progressive and less likely to use [manifest injustice] to intensify sentences. More diversion programs targeting minority youth exist in urban areas of Washington, and more African American youth are transferred to adult court; both reduce the likelihood of

minority youth receiving [manifest injustice]. Judges in rural areas of the state, which have fewer treatment resources, may be using [manifest injustice] to access services only available to court-involved youth." The authors noted that 71.2% of the African American population in Washington State reside in King and Pierce Counties. They note that the King County Juvenile Detention Alternative Initiative has also focused efforts to reduce racial disparities by implementing restorative principles and expanding diversion programs. The authors also state that, [Manifest injustice up or manifest injustice institutionalization] are used more often with Caucasian youth, which effectively means they have services in the community for longer periods of time or their placements at residential facilities are extended. These outcomes both restrict freedom while also allowing for critical interventions." The authors also state that it is the intent of judges in using manifest injustice is unclear; it is uncertain whether they use it for punishment or rehabilitation. However, when the authors looked at all youth residing in Washington State (including those not residing in juvenile justice facilities), "each of the minority groups had an increased risk of being adjudicated with [manifest injustice] to increase or intensify their sentence...This finding was greatest for African American youth, who were almost four times more likely than Caucasian youth to be sentenced with [manifest injustice intensified or manifest injustice institutionalization]." The article also notes that youth involved in the juvenile justice system have higher rates of mental illness compared to their peers.

66. Research Working Group Task Force on Race and the Criminal Justice System. Preliminary Report on Race and Washington's Criminal Justice System. *Washington Law Review*. 2012;87(1).

The Research Working Group, Task Force on Race and Criminal Justice System was Research Working Group, Task Force on Race and the Criminal Justice System convened in 2010 to address racial inequities in Washington's criminal legal system. The creation of the group was prompted by remarks of justices on the Washington Supreme Court that there was racial bias in the state's criminal legal system. Members of the Research Working Group include individuals from Washington State's schools of law. The larger Task Force includes representatives from a range of professional, legal, and community associations (e.g., Bar Association, Washington State Commission on Minority and Justice, prosecuting attorneys, advocacy organizations, etc.). In this report, the Research Working Group, Task Force on Race and the Criminal Justice System reports on disproportionality in Washington State's court, prison, and jail populations by race/ethnicity. The report concluded that, "Washington State criminal justice practices and institutions find that race and ethnicity influence criminal justice outcomes over and above [crime] commission rates." The Task Force found that the disproportionality in Washington State's criminal justice system, "is explained by facially neutral policies that have racially disparate effects...facially race-neutral policies that have a disparate impact on people of color contribute significantly to disparities in the criminal justice system. We find that racial and ethnic bias distorts decision-making at various stages in the criminal justice system, contributing to disparities." Lastly, "race and racial bias matter in ways that are not fair, that do not advance legitimate public safety objectives, and that undermine public confidence in our legal system."

67. Vastine K., Chester L. Act 201 Implementation: Vermont's Raise the Age Initiative - Joint Justice Oversight Presentation. 2019.

This presentation summarizes the background, findings, and recommendations related to implementing Vermont's Raise the Age Initiative. In 2018, the Vermont Legislature passed Act

201, which raised the age of juvenile jurisdiction to include 18 and 19 year-olds. The presentation provides background information on merging adults and states that 18-25 year-olds experience a distinct developmental stage marked by over-motivation to reward-seeking behavior, susceptibility to peer influence, and propensity toward risk-taking and impulsive behavior. The presentation notes that, "nearly all youth will mature and age out of crime." Data showed that 18 to 19 year-olds commit similar offenses to younger juveniles, and that "80% of potential cases are low-level and should be considered for diversion from the system." The presentation also states, "national data indicate emerging adults have the most racially disparate justice system outcomes of any age group."

68. **V Schiraldi, B Western, K Bradner. Community-Based Responses to Justice-Involved Young Adults. Harvard Kennedy School and National Institute of Justice; 2015.** This report aimed to present research in the area of criminal justice and young adult development as well as to present recommendations that focus on making the criminal justice system more developmentally appropriate for young adults. The authors refer to "young adults" as those ages 18-24. A robust body of evidence suggests that the human brain continues to develop well into a person's 20's and that "adult-quality" decision-making ability continues to develop into adulthood. Researchers discuss what is known as the "maturity gap" where cognitive functioning develops faster than psychosocial capacities and because of this, young adults are more likely to, "...engage in risk-seeking behavior, have difficulty moderating their responses to emotionally charged situations, or have not developed a future-oriented method of decision-making." The authors further discuss that psychosocial development is further disrupted by additional factors such as involvement in the justice system, traumatic incidents, parental incarceration, poverty, foster care, substance abuse, mental health needs, and learning disabilities. Next, the authors present data regarding the current landscape in the United States for young adults in the justice system. In 2012, about 130,000 young adults were admitted to a state or federal prison (21% of all admissions) and another 97,500 were released back to their communities (15% of all releases). Among this population of young adults released from prison, rates of recidivism were significantly higher than the total prison releasee population and researchers estimate that 78% of young adults released will be rearrested within 3 years.

69. **Prather Cynthia, Fuller Taleria R., William L. Jeffries IV, et al. Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. 2018;2.1:249-259.**

Prather et al. examined how historical racism negatively influences present-day health outcomes of African American women. racism is a fundamental determinant of health status, contributing to "social inequalities (e.g., poverty) that shape health behavior, access to healthcare, and interactions with medical professionals." Authors conducted a literature review of peer-reviewed sources and books (English only) to characterize the link between historical and current experiences of racism and sexual and reproductive health outcomes. Specifically, authors looked at Slavery (1619-1865), Black Codes/Jim Crow (1865-1965), Civil Rights (1955-1975), and Post-Civil Rights (1975-2018) eras. Results indicate "[t]he legacy of medical experimentation and inadequate healthcare coupled with social determinants has exacerbated African American women's complex relationship with healthcare systems." Additionally, authors found social determinants of health associated with institutionalized and interpersonal racism "may make

African American women more vulnerable to disparate sexual and reproductive health outcomes." They conclude that historical and enduring legacy of racism in the U.S. should inform the development of culturally appropriate programs, research, and treatment efforts to achieve health equity.

70. Alhusen J. L., Bower K. M., Epstein E., et al. Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. *J Midwifery Womens Health*. 2016;61(6):707-720.

Alhusen et al. conducted an integrative review of literature published from 2009 to 2015 examining the relationship between racial discrimination and adverse birth outcomes. Fifteen studies met the inclusion criteria (4 qualitative, descriptive studies; 11 quantitative studies - 8 convenience samples, 3 population-based studies using quota sampling and stratified sampling), and articles were assessed using the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA) 2009 framework. The majority of studies were conducted to assess the relationship between racial discrimination and adverse birth outcomes in African Americans. Three studies discussed experiences of institutionalized racism in both accessing and receiving prenatal care, and two studies examined racial discrimination during prenatal care and racial discrimination as a barrier to accessing prenatal care. African American women in one qualitative study described experiencing both interpersonal level (e.g., racial slurs directed at them) and institutionalized racism during prenatal care (e.g., differential treatment based on receipt of public assistance). One study reviewed used a biological marker to examine the effects of race and racial discrimination. Results indicate that at every point, African American women exhibited higher antibody titers than white women ($P < .001$). "The effect was most pronounced among African American women who reported experiencing higher levels of racial discrimination in the first and second trimesters ($P = .03$ and $P = .04$, respectively), supporting a role that chronic stress is related to this association." Authors conclude there is a significant need for the development and testing of interventions addressing racial discrimination at the provider level (i.e., students and professionals). They recommend interventions adapt a community-based participatory research framework to establish mutually respectful relationships grounded in learning, shared responsibilities, and capacity building. Additionally, relationship-based services like home visiting may be beneficial for individuals who experienced delayed access to prenatal care.

71. Serafin M. Health of Washington State Report: Self-reported Health Status. Data Update 2016. Washington State Department of Health; 2016.

Serafin presents data from Washington state on self-reported health status. The data show that after accounting for age, education, race and ethnicity, household income was a strong predictor of self-reported health status. Health status varied by race and ethnicity, with close to 35% of Hispanics, 30% of American Indian/Alaska Natives, and 20% of Native Hawaiian/Other Pacific Islander reporting fair or poor health. Washington Behavioral Risk Factor Surveillance System (BRFSS) data from 2012-2014 also show that education was a strong predictor of self-reported fair or poor health after adjusting for age.

72. Legislators National Conference of State. Juvenile Justice Guide Book for Legislators. 2011.

This report presents an overview of the state and federal landscape surrounding juvenile rehabilitation as well as the current research that demonstrates areas for improvement within the

juvenile justice system. The authors discuss neuroscience research that demonstrates that the average human brain is not fully developed until age 25, which means that young adults tend to have poor risk assessment skills, are vulnerable to peer influence, are more impulsive and emotional, and think about short-term rather than long-term consequences. The authors also report that young adults who were adjudicated as adults in New York were more likely to be re-arrested more often and for more serious offenses than those they were compared to in neighboring states.

73. Felson RB, Cundiff P, Painter-Davis N. Age and sexual assault in correctional facilities: A blocked opportunity approach. *Criminology*. 2012;50(4):887-911.

Felson et al. cite five studies which indicate that younger inmates in adult facilities are at greater risk than older inmates in these facilities of being sexually assaulted by staff and other inmates. The authors evaluated how age impacted the risk of being a victim of sexual and physical assaults in prisons and jails using 2000 to 2007 National Incident Based Reporting System (NIBRS) data. NIBRS data is compiled by multiple law enforcement agencies across the nation and only captures crimes reported by prison authorities. The authors only included male-on-male offenses in their analysis. The analysis included 12,188 incidents of assault, 674 of which were sexual assaults. The authors found that teenagers had the greatest risk of being assaulted with 18-19 year-olds being 7.7 times more likely to be victimized than 30-34 year-olds. The age category with the second highest risk of being a victim of sexual assault is ages 20-24. When considering sexual assault only, the data also show that offenders of all ages target young victims (under age 25). Assaults involving victims younger than 25 (particularly teenage victims) are the most likely to be sexual assaults. The odds that an assault is sexual is 390% higher for teenage assault victims than victims over 40. Assaults committed by older perpetrators are also more likely to be sexual than those committed by younger perpetrators.

74. Carns Joanna. Office of the Corrections Ombuds Annual Report. Olympia, WA: 1 November 2020 2020.

In this Annual Report, the Office of the Corrections Ombuds provides an overview of the Office's work and complaints received during Fiscal Year (FY) 2020. "OCO opened 2,983 cases, representing complaints from or regarding 1,882 incarcerated individuals. OCO was able to provide assistance or self-advocacy information in 40% of the cases." Complaints related to medical care were the most common concern in 2020 and have been since the OCO was established. For example, among concerns, OCO states, "people with serious mental illness reported receiving infractions for behavior while they were in the midst of a mental health crisis, and experiencing barriers to completing programs mandated for their release." One case OCO reviewed involved an incident that began with an individual experiencing a mental health crisis and self-harm and resulted in the individual "ultimately infractioned with a staff assault, placed in IMU, and lost custody points and good time." The Office recommends DOC ensure that individuals with a diagnosed mental health condition who are incarcerated "receive specialized consideration when involved in the internal DOC disciplinary system." Specifically, "DOC should ensure that those on the mental health caseload receive an expedited investigation, review, and hearing to reduce the total time in restrictive housing."

75. Kingsbury E. Systemic Report: Mental Health Access & Services. Olympia, WA: Office of the Corrections Ombuds; June 2021 2021.

This report from the Washington State Office of the Corrections Ombuds (OCO) systematically reviews access to mental health treatment and services in the Department of Correction's (DOC) correctional environments. OCO states, "We know that prisons house many people with complex mental health needs. It is critical that these needs be addressed both inside prison and once the person returns to the community, and yet DOC staff are often under-resourced and ill-equipped to provide the level of care that is needed." During its investigation, OCO determined that "people with past and present mental health conditions frequently are assigned to segregated housing for extended periods of time." For example, OCO received complaints which "describe the impact of segregation exacerbating symptoms of mental health disorders, sometimes resulting in destructive or self-harming behaviors, often resulting in infractions and sanctions, causing time in solitary confinement to be repeatedly extended or increasingly harsh." OCO found that people with diagnosed personality disorders are routinely placed in Intensive Management Units (IMUs), often due to persistent disruptive behavior or failing to engage in treatment. Staff expressed concerns that "symptoms may be exacerbated once placed in segregation" or that the "social and physical environment of IMU" may make it "difficult to effectively receive and benefit from treatment." OCO presented 22 recommendations for improvement of mental health services across the system, and DOC provided responses to each OCO recommendation. For example, staff recommended "DOC should ensure that an individual's mental health status is considered throughout the disciplinary process, including when reviewing infractions, determining guilt, and imposing sanctions." In response to Recommendation 9, DOC shared that in March 2021 it began piloting a new disciplinary process at Washington Corrections Center for Women and Monroe Correctional Complex-Special Offender Unit (SOU) for people with serious mental illness. "The pilot includes a review of serious infractions by a person's primary therapist... [which] is used to determine whether functional limitations contributed to the infraction and whether the person has the mental status to participate in the infraction hearing." If either is true, the infraction will be dismissed and "the treatment team is responsible for the development of an intervention plan to assist in the reduction or elimination of the concerning behavior." If it is not dismissed and the infraction is upheld, the treatment team will recommend a modified sanction designed to reduce or eliminate the behavior. The pilot was modeled after a program used by the Oregon Department of Corrections and is scheduled to conclude at the end of September 2021. Once reviewed and adjusted, it will roll out to other facilities in early 2022. Additionally, OCO recommended "DOC should reduce the frequency of placement and length of stay in any segregated housing, including A and B units of SOU, for individuals with mental health conditions." DOC responded that through its work with Vera and Amend it has reduced its Ad Seg population by one-third (Over 570 in 2012, 420 June 2021). It reported a 33% reduction in the median length of state in MAX Custody and a 45% reduction in self-harm/suicide attempts in restrictive housing. The department also stated that it has developed a more rigorous consideration process for requested extensions and increased scrutiny for those for which extensions are granted. Finally, OCO recommended DOC "explore best practices for successfully housing and treating individuals with behavioral challenges, regardless of diagnosis, in a setting that is not IMU or other segregated housing." DOC shared that it is in the process of expanding its continuum of care through intensive outpatient treatment, which it expects will allow some people's behavioral health needs to be met in general population. They reported having gathered information about programs implemented in New York and Massachusetts

correctional settings and were in the process of reviewing these as potential approaches to consider implementing in Washington.

76. Lydon J, Carrington K., Low H., et al. Coming Out of Concrete Closets: A Report on Black & Pink's National LGBTQ Prisoner Survey. 10.21.2015 2015.

This report by Black & Pink, self-described as "an open family of LGBTQ prisoners and 'free world' allies," summarizes findings of the 2014 National LGBTQ Prisoner Survey. Authors' note: "Given that there was no general agreement on terminology from respondents, we use the word 'prisoner' as an identifying term for all incarcerated individuals. We intentionally use the term 'prisoner' as it connects to the political reality of incarceration and aligns with the history of the Prisoner Rights Movement". The survey (133 questions) was drafted/designed in collaboration with LGBTQ prisoners. Nearly 7,000 prisoners each in September and November 2014 received the paper survey. A total of 1,118 people responded to the survey, "producing the largest ever dataset available on the experiences of LGBTQ prisoners in the country." Respondents represent "a selection of LGBTQ prisoners who have intentionally reached out for access to resources and who are willing to put themselves at risk to receive a newspaper that is known as an LGBTQ publication. As such, this report cannot claim to be representative of LGBTQ prisoner experiences." Respondents who shared their age (n=1,076) ranged in age from 19 to 71 years of age with an average age of 38. Of the 1,093 who self-identified race ethnicity, 43% were white, 26% Black, 11% Latin@/Hispanic, 13% mixed race, 6% Native American, and 2% other. In response to questions about gender and sexuality, 44% identified as a Cis man, Bi/Queer; 21% Cis man, Gay; 15% Trans woman; 7% Nonbinary gender; 5% Two-Spirit; 4% Cis woman, Lesbian; and 4% Cis woman, Bi/Queer. Among other topics discussed the survey addressed solitary confinement. The report outlines recommendations for policy makers and community organizers to address short-term, intermediate, and long-term efforts within specific advocacy areas. Specific to solitary confinement, results showed 85% of respondents reported having been placed in solitary confinement at some point during their incarceration, and approximately half had spent two or more years in solitary confinement. Approximately 50% of people reported being placed in solitary confinement "for their own protection but against their will." Meanwhile, 38% of respondents reported being housed in solitary confinement "for their own protection and at their request." For example, one person reported requesting solitary confinement, "[b]ecause the men was making me sell my body and it was the only safe place for me, the prison system won't help...so I ran to solitary to be safe." Another person shared, "I was placed in solitary after being raped...only released after it drove me to a suicide attempt." Furthermore, intersecting identities put some respondents at greater risk of being placed in solitary confinement. For example, among LGBTQ+ people, "Black, Latin@/Hispanic, mixed-race, and Native American/American Indian respondents were twice as likely to have been in solitary confinement, at the time of the survey, [as] white respondents." Additionally, those "with a mental illness diagnosis were more likely to be in solitary confinement at the time of the survey and more likely to have ever been in solitary confinement than survey respondents without such a diagnosis."

77. Implementation | PREA Standards | Prison and Jail Standards 2021; Available at: <https://www.prearesourcecenter.org/implementation/prea-standards/prisons-and-jail-standards>. Accessed May 17, 2021.

This National PREA Resource Center webpage details the National PREA Standards for prisons and jails.

78. **Implementation | PREA Standards | § 115.68 Post-allegation protective custody. 2021; Available at: <https://www.prearesourcecenter.org/standard/115-68>. Accessed May 17, 2021.**

This National PREA Resource Center webpage details the purpose of Standard § 115.68 Post-allegation protective custody.

79. **Implementation | PREA Standards | § 115.43 Protective custody. 2021; Available at: <https://www.prearesourcecenter.org/standard/115-43>. Accessed May 17, 2021.**

This National PREA Resource Center webpage details the Standard §115.43 Protective custody as well as its purpose.

80. **Rafferty J., American Academy of Pediatrics (AAP) Committee on Psychosocial Aspects of Child and Family Health; AAP Committee on Adolescence; AAP Section on Lesbian Gay, Bisexual, and Transgender Health and Wellness. Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents. *Pediatrics*. 2018;142(2).**

This American Academy of Pediatrics policy statement from the Committee on Psychosocial Aspects of Child and Family Health, Committee on Adolescence, Section on Lesbian, Gay, Bisexual, and Transgender Health and Wellness, reviews relevant concepts and challenges and provides suggestions for pediatric providers working with transgender and gender-diverse children and adolescents. AAP cites evidence estimating the U.S. transgender population as well as information indicating that children report being aware of gender incongruence at young ages (average 8.5 years) but often don't disclose such feelings until an average of 10 years later. The policy statement reports transgender adolescents and adults have higher rates of depression, anxiety, eating disorders, self-harm, and suicide. For example, a retrospective cohort study found 56% of transgender youth reported previous suicide ideation, and "31% reported a previous suicide attempt compared with 20% and 11% among matched youth who identified as cisgender, respectively. In regards to pubertal suppression, AAP reports "the available data reveal that pubertal suppression in children who identify as [transgender or gender-diverse] generally leads to improved psychological functioning in adolescence and young adulthood." They note treatment can reduce the need for later surgery by preventing otherwise irreversible secondary sex characteristics (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc.). Research on long-term risks of pubertal suppression (e.g., bone metabolism and fertility, is currently limited and provides varied results. Additionally, some experts believe that genital underdevelopment may limit some potential reconstruction options. Authors note that insurance denials for gender-affirming care are a significant barrier.

81. **Association American Medical. Issue brief: Health insurance coverage for gender-affirming care of transgender patients. American Medical Association; 2019 2019.**

This 2019 American Medical Association Issue Brief provides an overview of health insurance coverage for gender-affirming care of transgender patients. Authors provide background defining gender identity (i.e., an individual's concept of self as male, female, a blend of both, or neither), defines transgender persons (i.e. those individuals' gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth), and cites evidence estimating the U.S. population of transgender people (i.e., approximately 1.4 million adults and

150,000 youth ages 13 to 17 years). Additionally, "Individuals may also identify as gender expansive, meaning they identify with neither traditional binary gender role nor a single gender narrative or experience." This issue brief uses the term transgender as inclusive of patients with transgender or gender expansive identities. Authors note "many but not all transgender people experience gender dysphoria, a medical condition defined by the American Psychiatric Association as a 'conflict between a person's physical or assigned gender and the gender with which he/she/they identify.'" Authors go on to discuss barriers to care; federal and state policies that affect insurance coverage of gender-affirming care for transgender and gender expansive patients; potential cost savings of providing transgender inclusive health coverage; health implications for trans individuals; and medical society opinions by AMA and GLMA.

82. James S.E., Herman J.L., Rankin S., et al. The Report of the 2015 U.S. Transgender Survey Washington, DC: National Center for Transgender Equality; 2016.

This report summarizes the results of the 2015 U.S. Transgender Survey (USTS) and provides insights into the impact of stigma and discrimination on the health of many transgender people. The 2015 USTS is the largest survey examining the experiences of transgender people in the U.S. It includes 27,715 respondents from all fifty states, the District of Columbia, American Samoa, Guam, Puerto Rico, and U.S. military bases overseas. Respondents encountered high levels of mistreatment when seeking health care. For example, in the year prior to completing the survey, one-third (33%) of those who saw a health care provider had at least one negative experience related to being transgender (e.g., being verbally harassed or refused treatment due to their gender identity). "Nearly one-quarter (23%) of respondents reported that they did not seek the health care they needed in the year prior to completing the survey due to fear of being mistreated as a transgender person, and 33% did not go to a health care provider when needed because they could not afford it." Fifty-four percent of respondents to the U.S. Transgender Survey experienced some form of IPV and 24% reported severe physical violence by an intimate partner, compared to 18% of the U.S. population. The report also provides insight into the compounding impact of other forms of discrimination.

83. Ferdik F.V., Smith H.P. Correctional Officer Safety and Wellness Literature Synthesis. National Institute of Justice; 2017.

This National Institute of Justice (NIJ) report summarizes a review of literature related to correctional officer safety and wellness. Correctional officers work in facilities "supervising the activities of inmates, enforcing rules and regulations, affording [individuals] access to social services, and perhaps most importantly, maintaining order." The report stated that, "many scholars conclude that employment as a [correctional officer] is among the most dangerous and life threatening of all professions, including law enforcement." NIJ noted that, "officers are required to interact with and supervise potentially dangerous [individuals] in relatively unsafe and secluded surroundings." Moreover, "prisons [are] dangerous environments that carry increased risk of harm to the people working in them." Correctional officers may experience multiple work-related dangers, including exposure to infections and communicable disease, prison gangs, disruptive inmates, contraband, riots, and working with individuals with mental health concerns. They experience increased risk of physical and mental health concerns, including increased risk of injury, heart disease, diabetes, high cholesterol, hypertension, stress, burnout, etc. A 2011 study found that 31% of correctional officers reported serious psychological distress, which is twice the rate of the general public. A 2012 study found that 27 percent of correctional

officers reported symptoms of post traumatic stress disorder, which is almost twice the rate of combat Veterans (14%). Research has also found that correctional officers experience death by suicide at twice the rate of the general public. Correctional officers also experience lower life expectancy; “the average lifespan of individuals in this line of work was 59 years, some 16 years below the national average of 75.” NIJ noted that previous research has found that “some officers are assigned to more dangerous units of the prison (e.g., administrative segregation), which can increase their risk of physical and mental health problems.” In 2011, correctional officers “experienced 544 work-related injuries or illnesses that required absences from work per 10,000 full-time officers—the third highest rate of nonfatal workplace injuries...surpassed only by police officers and security guards.” Studies have found that between 22% and 35% of correctional officers report high levels of stress. These negative health impacts “can have deleterious effects on the wider prison institution. Staff shortages and officer absences from work can create a cycle whereby low officer-to-inmate ratios and high turnover in officer staffing threaten the effective implementation of a correctional facility’s security mandates.” Correctional officers may also experience work/family conflict that further impacts psycho-social health. The NIJ report also included a review of literature related to correctional officer’s perception of workplace safety. The review included 8 articles examining a range of safety-related issues, including exposure to infectious disease, risk of injury, and risk of victimization by individuals who are incarcerated or coworkers. The studies found that correctional officers perceived their risk of various safety-related issues to be high. For example, one study found that 92.2 percent of officers believed they were at risk of contracting Hepatitis B or C. Another study found that between 57 and 73 percent of officers believed they were at risk of victimization by individuals who were incarcerated. Overall, researchers also found that “higher levels of stress were significant predictors of three variations of officer burnout: depersonalization, emotional exhaustion, and job ineffectiveness.” Moreover, “many studies have found safety and wellness risks within the correctional environment to significantly influence officers’ desire to use administrative sick leave as well as their desire to resign.” A study examining data from 2000 to 2008 found that 16.2% of correctional officers resigned after only three years on the job, and “elevated rates of officer turnover and absenteeism can lead to higher inmate-to-officer ratios and greater numbers of inmate-on-inmate and inmate-on-staff assault.”