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Testimony of Lauren Brinkley-Rubinstein, PhD

I am Lauren Brinkley-Rubinstein, an associate professor in the Department of Social Medicine and the Center for Health Equity Research at the University of North Carolina at Chapel Hill. I am trained as a community psychologist and my research attempts to understand the community or population level effects of social or structural determinants of health such as incarceration. I have been conducting this research for over 15 years. One area of study in which I have expertise is the conditions of confinement and how they impact people who reside in prisons and jails. An important condition of confinement that is widely known to negatively impact people's health is solitary confinement.

Solitary confinement is defined as the practice of isolating individuals who are incarcerated in small cells for 22 to 24 hours a day. People housed in these settings are exposed to social isolation, sensory deprivation, and physical idleness. Additionally, these individuals have less access to programming, visitation, and other privileges available to the general population. Carceral systems typically use solitary confinement for disciplinary purposes (eg, when someone breaks a rule) or for administrative purposes (eg, to isolate someone who may otherwise be at risk of experiencing or committing violence).

In 2015, the United Nations revised the Standard Minimum Rules on the Treatment of Prisoners to include the Mandela Rules, which for the first time clearly defined solitary confinement and provided guidelines on its use. Specifically, the Mandela Rules state that solitary confinement should only be used in exceptional circumstances and never for more than two consecutive weeks. The Mandela Rules also explicitly define prolonged solitary confinement as a form of torture.

A growing body of literature has documented the association of solitary confinement with the health of people who have been incarcerated. Individuals with mental illness are overrepresented in most solitary confinement units. These individuals are particularly susceptible to psychological deterioration while isolated in solitary confinement, which can manifest as reclusiveness, social withdrawal, psychosis, self-harm, posttraumatic stress disorder, and suicide. Myself and my colleagues have added to this body of literature by conducting a study that was published in the Journal of the American Medical Association (JAMA) open network looking at the association between mortality, opioid overdose death, homicide, and suicide, and reincarceration in North Carolina between 2000 and 2016 and solitary confinement. In addition, we examined the association of mortality with the following: (1) repeated solitary confinement stays, and (2) time spent in solitary confinement using the Mandela Rules guidelines.

We found that people who had spent any time in solitary confinement during incarceration in a state prison in North Carolina were significantly more likely to die of all causes in the first year after release than those who did not. In addition, our results demonstrated that death by suicide and homicide in the first year and opioid overdose in the first two weeks after release were more common among those who had experienced solitary confinement compared with those who were incarcerated but never in solitary confinement. Further, the risk of death and reincarceration was

higher among individuals with more solitary confinement placements and among those who spent more than 14 consecutive days in solitary confinement. These results suggest that exposure to solitary confinement, as a condition of confinement, may be a contributing factor to the risk of death during community reentry. Our findings also point to an exacerbation of risk when people are placed in solitary confinement repeatedly and for longer periods, underscoring the importance of the Mandela Rules guidelines.