Restrictive Housing Oversight Committee

Inaugural Report

to

Chairs Michael S. Day and Lydia Edwards, Joint Committee on the Judiciary

Chairs Daniel Cahill and John J. Cronin, Joint Committee on Public Safety and Homeland Security

February 27, 2025

Table of Contents

I. Acknowledgements

The Committee would like to extend its gratitude to the senior staff members, corrections officers, medical and mental health professionals, and incarcerated people at the Department of Correction and Jails and Houses of Correction who graciously engaged with Committee members during site visits. Leadership and senior staff members at the facilities the Committee visited were extremely accommodating, allowing the Committee full access to their Restrictive Housing units, general population units, and in many cases medical and mental health units or other specialized units. Requests for inmate lists, population counts, tours and interview space were always granted, even though these requests often presented logistical challenges. The Committee would also like to thank the Department of Correction and the Sheriff's Offices that responded to the Committee's voluminous requests for documents and data.

Most importantly, the Committee appreciates the time that both staff and incarcerated people spent meeting with Committee members to discuss the important topic of Restrictive Housing. The Committee found most staff to be engaging, thoughtful and dedicated to improving conditions at their respective facilities. Sometimes, particularly in the immediate aftermath of changes resulting from the 2018 Criminal Justice Reform Act, corrections officers voiced their concerns and frustrations with the new law. Likewise, the Committee found most incarcerated people who chose to be interviewed to be engaging, thoughtful, and well-intentioned as they described their experiences in Restrictive Housing, both before and after the effective date of the Criminal Justice Reform Act. The Committee found its discussions with staff and incarcerated people invaluable to its work and many of these conversations informed this report. The Committee also wishes to express its gratitude to members of the public who dedicated many hours listening to our public meetings and offering thoughtful comments and concerns. A few individuals joined and participated in almost all the Committee's public meetings spanning the past several years, and we greatly appreciate their commitment and valuable insights.

Finally, the Committee would like to extend its gratitude to its Chair, the Executive Office of Public Safety and Security ("EOPSS") Undersecretary, Andrew Peck, whose steadfast leadership and calm demeanor guided a group of passionate members with diverse backgrounds and experiences to work together in common purpose to deliver this report, as well as EOPSS Criminal Justice Advisor Michaela Martini who provided constant administrative support on behalf of EOPSS. We also thank John Melander, EOPSS Deputy General Counsel, who provided us with very helpful legal assistance, especially regarding the Open Meeting Law and the implications of the pandemic on our work, and who was the primary editor of this report.

II. Introduction

On April 13, 2018, the Commonwealth of Massachusetts passed chapter 69 of the Acts of 2018, an *Act Relative to Criminal Justice Reform*, ("CJRA or "Act"), a landmark criminal justice law to update and modernize existing laws and establish new laws to provide for a more equitable administration of the Commonwealth's system of criminal justice.[1] A key component of the CJRA includes the rights of persons incarcerated in correctional institutions, with a particular focus on individuals placed in Restrictive Housing ("RH") units. As part of the Act, the Legislature created the Restrictive Housing Oversight Committee ("RHOC" or "Committee"), which is required to

gather information regarding the use of Restrictive Housing in correctional institutions throughout the Commonwealth "to determine the impact of Restrictive Housing on inmates, rates of violence, recidivism, incarceration costs and self-harm within correctional institutions."[2] The RHOC is directed to generate "a report offering its recommendations on the use of Restrictive Housing in the commonwealth, including ways to minimize its use and improve outcomes for prisoners and facility safety," including:

> (1) the criteria for placing an inmate in Restrictive Housing;
>
> (2) the extent to which staff who work with prisoners in Restrictive Housing receive specialized training;
>
> (3) the results of evaluations of the process of Restrictive Housing in the commonwealth and other states;
>
> (4) the impact of use of Restrictive Housing on prison order and control in correctional facilities;
>
> (5) the cost of housing an inmate in Restrictive Housing compared with the cost of housing an inmate in general population; and
>
> (6) the conditions of Restrictive Housing in the commonwealth.

Pursuant to subsection (a) of section 39G of chapter 127 of the General Laws, the Secretary of the Executive Office of Public Safety and Security or a designee, shall serve as the Chair of the Committee, and the Commissioner of the Department of Correction or a designee, and the Commissioner of Mental Health or a designee shall be members of the Committee. Additionally, the Governor shall appoint (9) members with various and diverse professional backgrounds.

The members of the Committee are as follows:

Andrew Peck, Chair
Undersecretary of Criminal Justice, Executive Office of Public Safety and Security
(April 2019-Present)

Joanne Tsakas Barros, PhD, LMHC, CCHP
Director of Jail/Arrest Diversion Initiatives (Statewide), Department of Mental Health
(September 2021-Present)

Thomas Bowler
Sheriff of Berkshire County
(April 2019-Present)

Kevin Flanagan
Legislative Representative, Massachusetts Correction Officers Federated Union (MCOFU)
(April 2019-Present)

Robert Fleischner, J.D.

Massachusetts Association for Mental Health (MAMH)
Designee of the President/CEO of MAMH
(April 2019-Present)

Brandy Henry, PhD, LICSW
Criminal Justice Committee, National Association of Social Workers Massachusetts Chapter
(April 2019-Present)

Hon. Geraldine Hines (Ret.)
Former Associate Justice of the Supreme Judicial Court
(April 2019-Present)

Hollie Matthews
Deputy Director of Strategic Planning and Research, Department of Correction
(April 2019-Present)

Kyle Pelletier
Director of Special Programs, Department of Correction
(September 2021-Present)

Tatum A. Pritchard, JD
Director of Litigation, Disability Law Center
(March 2021-Present)

Bonita Tenneriello, Esq.
Senior Attorney, Prisoners' Legal Services
(April 2019-Present)

Former Members:

Christopher Fallon
Deputy Commissioner, Department of Correction
(April 2019-April 2022)

Anthony Riccitelli
Director of the Office of Inpatient Management, Department of Mental Health
(April 2019-September 2021)

Sean Medeiros
Assistant Deputy Commissioner, Department of Correction
(April 2019-September 2021)

Marlene Sallo, JD
Executive Director of the Disability Law Center (formerly)
(April 2019-March 2021)

Non-voting Members:

Dennis Everett
(October 2021-Present)

Romilda Pereria
(October 2021-Present)

The Committee was supported by board counsel John H. Melander, Jr., Deputy General Counsel at EOPSS, Michaela Martini, Criminal Justice Advisor at EOPSS, and Adrian Hatch, Paralegal at EOPSS.

The CJRA aimed to reduce reliance on Restrictive Housing, defined by the Legislature as confinement to a cell for more than 22 hours per day, by (1) limiting its use to those serving a disciplinary sanction or those whose retention in general population poses an unacceptable risk to safety, property or correctional operations; (2) excluding those who are vulnerable due to serious mental illness or other factors; (3) prohibiting its use for those in need of protection or due to lesbian, gay, bisexual, transgender, queer or intersex identity; and (4) requiring reviews to determine whether persons held in Restrictive Housing pose an unacceptable risk[3]. In response to the law, the DOC and various county facilities made changes to the operations and experiences of Restrictive Housing units.

III. Executive Summary

For the purposes of this report, the RHOC has focused its most in-depth review of conditions and use of Restrictive Housing on the years of 2019 - 2021. This report will serve as a baseline report to examine the system of Restrictive Housing in the Commonwealth as it existed since the passage of the CJRA, and how it has evolved since then. This includes understanding the conditions of Restrictive Housing across the Commonwealth to compare the changes currently being implemented, primarily at the Department of Correction (DOC), as well as changes within some county facilities. This report will also seek to separate discussion of conditions in the DOC and those in various counties as much as possible, and to evaluate past practices for the noted time frames.

Narrowing the timeframe of this report is critical to understanding the state of Restrictive Housing immediately following the implementation of the CJRA. Even with this narrowed time frame, the Committee has sometimes found it difficult to draw clear conclusions from the experiences, use, and conditions of Restrictive Housing as it continues to evolve. Some of these changes in practices were initially observed by the RHOC and as such are commented on within this report even though they may no longer be in use. Other changes were not reviewed by this body in full.

A further complication is that it is difficult to draw conclusions about the use of Restrictive Housing across the Commonwealth's County facilities due to distinct populations, sizes, and how the data have been reported over time. Specifically, gaps exist in the data on use of Restrictive Housing, as some counties did not report on any 22-hour confinement, while others increased out of cell time to 2.25 or 2.5 hours daily and thus did not report data. These gaps appear in monthly Restrictive Housing census reports as well as the more detailed reporting required annually, which the counties have thus far provided for 2019, 2020, 2021, 2022, and 2023, and are inconsistent in some categories such as reason for placement and racial demographics.[4] Even with these gaps, those counties that have reported data provide some insights into the level of usage, age, and mental health status of those held in Restrictive Housing.

Beginning in 2022, after the period covered by this report, the Department of Correction began the process of replacing former Restrictive Housing units with alternative units, pursuant to the recommendations of consultants from the Falcon Group, as discussed later in this report.[5] This began with the creation of new units to replace traditional Restrictive Housing and was completed by June of 2023, when the Department closed the Department Disciplinary Unit (DDU). The RHOC has been informed of these changes regularly, including several public briefings to the Committee directly from the Falcon Group, and recognizes that this process was completed ahead of schedule. However, the RHOC has not yet systematically conducted the interviews with incarcerated people and staff, and the gathering of information necessary to assess the functioning of these units. The Committee intends to continue its work by examining these new units to provide future reports on their use, conditions, and effectiveness. The Committee believes that it is important that these alternative, non-general population units are studied closely to understand how they are functioning, whether and how they differ from the former Restrictive Housing units, and whether these units are an improvement over the Restrictive Housing system previously used by the DOC. To that end, the Committee plans to continue visiting state and county facilities, engaging with staff and incarcerated people, and reviewing data on these alternative units to gain a better understanding of them and to identify any shortcomings or areas to improve upon, all to be included in a future report. The Committee also intends to continue oversight of county facilities with both 22-hour Restrictive Housing and with segregated units that offer slightly more out of cell time. The Committee assumes that DOC's experiences with the alternative units will be instructive for the county facilities.

IV. Methodology

The original RHOC members were appointed beginning in 2018, and the Committee first convened in April 2019. The Committee has met continuously since then, for the most part once per month. Agendas for meetings were posted on the Committee's website prior to each meeting in accordance with the Open Meeting Law.[6] Initial meetings focused on information gathering from diverse experts in Restrictive Housing. Invited guests who addressed the RHOC included:

- August 5, 2019: Dr. Lisa Ann Peterson (North Dakota Department of Corrections). Implementation of reducing Restrictive Housing in North Dakota.
- January 23, 2020: Jamelia Morgan (then Associate Professor of Law and Robert D. Glass Scholar at the University of Connecticut School of Law). Disability &

Restrictive Housing, focusing on psychiatric disabilities and using treatment as opposed to punishment.

- February 19, 2020: Formerly incarcerated speakers, Tyler Brown and Jurell Larona. Lived experiences of Restrictive Housing, highlighted cultural issues within prisons which may exacerbate behavior leading to RH placement, and how placement in Restrictive Housing contributes to difficulty with reentry after release.
- February 19th, 2020: RHU Correctional Officer speaker, Lt. James Allain. Lived experience of working in RH, including exposure of staff to trauma/violence/physical hazards.

Each meeting included time for public comments. Members of the public commented at nearly every meeting. These comments brought new and useful information to the Committee and provided a meaningful mechanism for public engagement. Minutes of each meeting were recorded and approved, sometimes with amendments, at a subsequent meeting. The minutes are posted on the Committee's website.[7]

The Committee organized itself into several subcommittees, each charged with considering a specific matter upon which the Legislature directed the Committee to report. Subcommittees met as needed and meeting notices and agendas were posted in accordance with the Open Meeting Law. Much of this report was drafted by the subcommittees. EOPSS staff that supported the Committee also staffed the subcommittees. The subcommittees and their respective members are:

The Results of Evaluations of the Process of Restrictive Housing in the Commonwealth and Other States subcommittee

1. Anthony Riccitelli (Mr. Riccitelli concluded his service on the board in September 2021 and was replaced by Joanne Tsakas Barros)
2. Sean Mederios (Mr. Medeiros concluded his service on the board in September 2021)
3. Robert Fleischner, J.D. Esq. (Subcommittee Chair)
4. Brandy Henry, PhD, LICSW

The Impact of Restrictive Housing on Prison Order and Control in Correctional Facilities subcommittee

1. Hollie Matthews (Subcommittee Chair)
2. Kevin Flanagan
3. Sheriff Thomas Bowler
4. Marlene Sallo, Esq. (Atty. Sallo concluded her service on the board in March 2021 and was replaced by Tatum Pritchard)

The Conditions of Restrictive Housing in the Commonwealth subcommittee

1. Christopher Fallon (Mr. Fallon concluded his service on the Committee in April 2022)
2. Hon. Gerri Hines (Ret.)

3. Bonita Tenneriello, Esq. (Subcommittee chair)
4. Undersecretary Andrew Peck

Additionally, Committee members visited 7 DOC facilities and 10 county facilities. Most of these visits occurred prior to the COVID-19 pandemic, however, eventually the Committee elected to resume site visits, at first using available technologies to participate virtually and later utilizing a hybrid approach.

Members of the Committee visited the following DOC facilities:

FACILITY	DATE 1	DATE 2	DATE 3 (if applicable)
MCI-FRAMINGHAM	10/28/2019	10/29/2019	3/7/2023
MCI-CONCORD	11/6/2019	11/7/2019	1/12/2023
MCI-NORFOLK	12/2/2019	2/10/2020	3/3/2023
OLD COLONY CORRECTIONAL CENTER	12/10/2019	12/11/2019	
MCI-CEDAR JUNCTION	12/16/2019	12/17/2019	
SOUZA-BARANOWSKI CORRECTIONAL CENTER	1/7/2020	1/8/2020	1/18/2023
MCI-SHIRLEY	2/26/2020	2/27/2020	

Members of the Committee visited the following county facilities:

COUNTY	DATE 1	DATE 2
BARNSTABLE	1/14/2020	1/15/2020
ESSEX	1/21/2020	1/22/2020
HAMPSHIRE	2/5/2020	2/6/2020
PLYMOUTH	2/12/2020	2/13/2020
BERKSHIRE	3/9/2020	3/10/2020

BRISTOL	5/4/2021	
MIDDLESEX	2/20/2020	2/21/2020
WORCESTER	3/3/2021	3/4/2021
FRANKLIN	6/14/2021	6/15/2021
SUFFOLK	6/28/2021	6/29/2021

The Committees visits were normally conducted over two days, with a different group of members attending each day. The Committee conducted most site visits in a similar manner by first meeting with facility leaders, typically a Superintendent, Deputy Superintendent, or Sheriff, among other senior staff members, followed by a general tour of each facility with a particular focus on Restrictive Housing units. Members then conducted voluntary interviews of incarcerated persons, focusing on those currently in Restrictive Housing. The Committee developed a set of standardized questions to discuss with each incarcerated individual to guide conversations and help gather information on particularly important areas of concern such as access to out-of-cell time, showers, visitors, phone calls, canteen, etc. The Committee also held focus group meetings where it met with a group of individuals who had been placed in Restrictive Housing at some point during their incarceration. All these interviews and interactions were done on a voluntary basis following a review and signing of an informed consent acknowledgement. The Committee found these interviews and interactions to be invaluable to its work. In almost every instance, the Members found the incarcerated individuals to be respectful, engaging, sincere, and knowledgeable about the subject matter and willing to offer constructive criticism of the system, areas needing improvement, as well as things they thought worked. In almost every instance, the Members found the incarcerated individuals to be respectful, engaging, sincere, and knowledgeable about the subject matter and willing to offer constructive criticism of the system, areas needing improvement, as well as things they thought worked. None of the incarcerated people with whom the Committee spoke are identified by name in this report. Nonetheless, their observations and comments significantly informed our work.

Additionally, Committee Members met with correctional officers, including unit supervisors, and with medical and mental health staff. These roundtable discussions provided Members the opportunity to ask general and specific questions relating to day-to-day operations and to hear directly from staff about their experiences, including challenges, criticisms, and what they believed worked versus what they believed did not work. We also talked individually and informally with facility staff throughout the course of most of the tours of the facilities. These candid conversations were very helpful to the Members, particularly in the wake of the CJRA and all the changes that had recently occurred. No staff members are identified by name in this report, but they too informed the Committee’s work.

V. Use of Restrictive Housing in the Commonwealth

Overview

The level of use of Restrictive Housing varies between the Department of Correction and the counties, as well as among the county facilities. This section breaks down the use of Restrictive Housing from 2019 to the end of 2021 by agency type. The Department of Correction has consistently provided all the data required by the CJRA or requested by the Committee. Therefore, we have been able to evaluate, make observations and consider trends regarding the DOC's use of Restrictive Housing during this time. This level of cooperation has been valuable to the work of this Committee. In contrast, this report lacks much detail on the use of Restrictive Housing at the county level due to the lack of data provided by the Counties and the timeliness of what was received. This lack of data sharing has limited our ability to make the same scope of observations about the Counties that we have about the DOC. The lack of similar observations should therefore not be interpreted as lack of disparity or use, but rather due to a lack of information.

Specifically, the DOC and some counties reported data on all confinement of 22 hours or more per day (in line with national and international standards), but many other counties relied on a narrow interpretation of the CJRA definition to justify not reporting on 22-hour confinement.[8] This created gaps and inconsistencies in both the monthly reports and the annual reporting required by the counties. At the same time, other counties began offering 2.25 or 2.5 hours out of cell and thereby took their confinement outside of the CJRA definition of Restrictive Housing. Finally, while the DOC is required to report detailed information quarterly, and has done so diligently, counties are required by the CJRA to provide detailed information only annually, making it more difficult to track trends and developments. Further, many counties omitted 22-hour confinement from these annual reports for the reason described above.

A. Department of Correction

Approximately a year after the CJRA went into effect, the DOC contracted with consultants from the Falcon Correctional and Community Services, Inc. to conduct a systemic evaluation of its use of Restrictive Housing and related policies and make recommendations.[5] Falcon's report, released in March 2021, made several recommendations. In accordance with these recommendations, in June 2021, the Department of Correction made public its commitment to end Restrictive Housing in all forms, to include closing the Department Disciplinary Unit (DDU).[9] The RHOC has been updated periodically by Falcon's experts, and monthly by DOC Committee members, on the status of that implementation, and to date is aware the DOC proclaims that it no longer uses RH to respond to risks in their general population. This was accomplished by the opening of Behavior Assessment Units (BAUs), and a redesign and enhancement of the DOC's Secure Adjustment Units (SAUs). The Department closed the DDU in June 2023, a move that was widely welcomed.[10] Detailed reporting of the implementation of the Falcon recommendations and oversight of the changes are outside the basic time frame and overall scope of this report. However, the RHOC has visited some of the newly created units and acknowledges the DOC's sincerity and commitment to making substantial changes. The goal of ending Restrictive Housing is broadly welcomed, and some positive changes were evident in the site visits made by the Committee.

However, some members of the public who spoke at Committee meetings, some incarcerated individuals the Committee has interviewed during visits, and some Committee members have raised concerns that some of these units renders them close, or equivalent, to the former Restrictive Housing. Some have criticized the new units overall as punitive rather than rehabilitative in practice and have noted that they hold as many if not more people than the former Restrictive Housing units. The RHOC takes these concerns seriously. The Committee is also concerned about potential racial and age disparities in these alternative units. The Committee plans to review these practices over the next year and have a complete report of their use, conditions, and status.

Level of use of DOC's Restrictive Housing 2019-2021

The DOC used Restrictive Housing for two distinct purposes during the three-year period between 2019 and 2021. First, non-disciplinary Restrictive Housing in Restrictive Housing units (RHUs) was used to remove individuals from general population at their medium and maximum-security prisons for behavior which staff determined posed an unacceptable risk to safety and security. Secondly, disciplinary Restrictive Housing was used as punishment for disciplinary convictions, both as a short-term sanction (15 days or less) in Restrictive Housing units, and long-term disciplinary sanction of up to ten years for specific offenses, in the Departmental Disciplinary Unit (DDU). These types of Restrictive Housing were used differently and have noted confinement differences which are important to distinguish. The data provided by the DOC during the relevant period have allowed this Committee to distinguish between these types of use.[11]

Non-disciplinary and short-term disciplinary confinement in DOC's RHUs

The DOC's reliance on Restrictive Housing declined from 2.9% of its custody population in January 2019 to 1.9% in December 2021.[11] The absolute numbers fell dramatically during that period, from 244 to 116, as the DOC's total custody population dropped by 29%. The months of January and December were selected since they were the first and last months of the period under review. However, these months may not be representative of overall trends due to potential impacts of holidays at the end of the year. Therefore, throughout this section any conclusions about actual overall changes in population should be made cautiously.

Level of long-term Restrictive Housing in the DDU

During the relevant period, a subset of DOC's Restrictive Housing population was held in long-term Restrictive Housing within the DDU, with disciplinary sanctions of up to ten years per offense for the most serious offenses, as outlined in DOC regulations.[12]

Though comparatively small, this population was the group most severely affected by Restrictive Housing and therefore an important barometer of the CJRA's success in reducing reliance on Restrictive Housing. The proportion of DOC people held in the DDU decreased from 1.11% in January 2019 to 0.60 % in December 2021.[11] In absolute terms, it fell from 94 in January 2019 to 36 in December 2021, a 61.7% reduction, as the DOC population declined by just under 30%. Detailed quarterly data reporting, available through the fourth quarter of 2021, shows the length of sanction of those held in the DDU.[13] The proportion serving longer sanctions increased

as the total population fell, consistent with a decline in new admissions and the continued enforcement of long sanctions. The proportion of DDU prisoners held for six months (a relatively short term only in the context of sanctions up to ten years) fell from a 19.67% to 13.95%, while those serving sanctions over two years rose from 23.77% of the total to 37.21%.[13]

Race and Ethnicity disparities in the DDU and RHU[14]

Based on the first quarter of each year, quarterly reporting available on individuals serving DDU sanctions from 2019 through the end of 2021 shows on average those reporting a race/ethnicity of Black/African American were over-represented by 13% compared to their presence in the DOC male custody population January 1st snapshot data, 2019 - 2022**Error! Bookmark not defined.**[11] This was nearly mirrored by under-representation of those self-reporting a race/ethnicity of White. Overall, in absolute terms, the number serving DDU sanctions fell from 122 during the first quarter of 2019 to 43 during the fourth quarter of 2021.[13]

Racial disparities within RHUs outside of the DDU were more mixed, varying over time. In the first quarter of 2019, white individuals held for disciplinary detention in RHUs were over-represented by almost 4%, while Black/African American and Hispanic individuals were slightly under-represented.[13] During the first quarter of 2020, Hispanic individuals were over-represented by 6.7%, while White and Black/African American individuals were under-represented, 4.18% and .55%, respectively. Starting in 2021, Black/African American and Hispanic individuals were both over-represented, with the over-representation of those self-reporting a race/ethnicity of Black/African American reaching a high of 9.7% during the first quarter of 2021, and the over-representation of Hispanic individuals reaching a high of 6.8% during the first quarter of 2021.

The overrepresentation people of color in the DDU and later in the RHU is not unique to Massachusetts. The Vera Institute of Justice in a 2018 report noted that “as in other parts of the justice system, Restrictive Housing often affects disproportionate numbers of young people, people living with mental illness, and people of color."[15]

Its study of practices in five correctional systems concluded, “[o]verall, people of color at Vera’s partner sites had higher rates of contact with Restrictive Housing than white people did—especially with the most severe types of this housing—and were underrepresented in more treatment-oriented forms of Restrictive Housing and other less-stringent alternatives.”[15] RHOC member Brandy F. Henry, analyzing data from a national survey by the U.S. Bureau of Justice Statistics, determined that nationally Black incarcerated people were subject to solitary confinement as a disciplinary punishment 1.36 times more than white individuals, Hispanics 1.22 times more, and multiracial individuals 1.4 times more.[16]

Various factors may contribute to racial disparities in Restrictive Housing. As Dr. Henry writes, racial bias similar to that documented in criminal sentencing may be at play:

> Past research related to sentencing bias supports the existence of racial and ethnic bias towards harsher criminal sentences for people who are Black, Hispanic and native American. Given that due process must be followed during prison based disciplinary proceedings, and the fact that prison

officials have considerable discretion in the use of disciplinary action, it is likely that similar "sentencing bias" was operating here.[17]

Age in DOC's Disciplinary Restrictive Housing

The DOC's quarterly reports include the age of each person held in disciplinary Restrictive Housing, pursuant to G.L. c. 127, §39D (b)(iv). Youthful and elderly people have vulnerabilities to Restrictive Housing that merit special attention. It is worth noting that age information is not reported for persons held in non-disciplinary Restrictive Housing and so that is not discussed here.

Youth in DOC's Disciplinary Restrictive Housing

A 2018 literature review by the DOC noted, "[t]he acknowledgement of the period of late adolescence/young adulthood as a time of continued brain growth and maturation and that this age group is resilient to change speaks to the need for different tactics to deal with this population in the criminal justice system. In addition, the research shows that brain maturity continues through the mid-twenties."[18] The review cites scientific studies showing brain maturation into the early to mid-twenties, and that "regions of the brain that are the last to develop are the ones that are affiliated with making good decisions and controlling impulses and have implications regarding blameworthiness."[19] Similar research also shows that youth are more susceptible to peer pressure, have less impulse control, and are less risk averse than persons with more developed brains. The United States Supreme Court and the Massachusetts Supreme Judicial Court have relied on this science in several cases involving sentencing of juveniles.[20] This research calls into question the use of Restrictive Housing as punishment for young adults. In a correction setting this group of individuals tend to create the most harm in the system due to their underdeveloped impulse control, decision making, and future orientation, which can lead to increase rates of violence or more extreme actions.[18]

In addition, a body of evidence shows that young adults are particularly vulnerable to harm from solitary confinement.[18] Because young people are still in the formative stages of development, they generally "possess less mental and emotional resilience than adults and are even less able to cope with the isolating conditions of solitary."[21] Restrictive Housing can have developmental impacts, including alterations in brain structure and function, and can cause greater psychological harm in youth. [22] Advocates against solitary confinement argue that young people's still-developing brains can also lead them to behavior in response to isolation that cyclically leads to more time in isolation.[23]

The relevant age group for young adults is generally defined in the literature as 18 to 25 years old.[18] The percentage of this age group in the general DOC prison population was around 5%, during the relevant period but the percentage of such youth in Restrictive Housing during that timeframe was much higher.[13] Of particular concern, this age group continued to be held in long-term Restrictive Housing in the DDU. In Q1 of 2019 those 18 to 25-year-old made-up 24.59% of the DDU population, and after substantial fluctuations they comprised 16.28% in Q4 of 2021. In absolute terms, as the DDU population declined, so did the number of youths held there, dropping from 30 in Q1 of 2019 to 7 in Q4 of 2021. (The number of those 21 years old or younger in the DDU – the most vulnerable due to youth – ranged from 8 in Q1 of 2019 to 2 in Q4 of 2021.) The percentage of those held in shorter-term disciplinary detention (DD) outside of the DDU that were 18 to 25 years old dropped slightly from nearly 16.6% in Q1 of 2019 to just over 14% in Q4 of

2021, though in absolute terms these numbers are higher than in the DDU, ranging from 82 in Q1 of 2019 to 36 in Q4 of 2021. (Those 21 and under in DD numbered 28 in Q1 of 2019 and 6 in Q4 of 2021.)[13]

It is perhaps not surprising that young adults would be overrepresented in disciplinary Restrictive Housing. This trend also exists nationally, as noted in the aforementioned research by Dr. Henry.[17] Locally, on more than one RHOC site visit, staff and older incarcerated individuals said that younger people in custody engage more frequently in violent misconduct, in keeping with the generally accepted understanding that people tend to "age out" of crime and misconduct.[24] This is also consistent with the brain development issues referenced above. The potential for Restrictive Housing – especially long-term confinement such as the DDU – to cause harm to young adult brains which are still developing and thus more vulnerable is even more reason to create alternatives that offer opportunity and treatment to those at risk, rather than restrictive conditions.

Elders in disciplinary Restrictive Housing

Social isolation can have harmful effects on cognitive function in people 55 and older.[25] Restrictive Housing reduces access to auditory and visual stimuli; this sensory deprivation can worsen confusion and memory loss for older adults. Many elders experience some degree of hearing loss. Those with hearing impairments face even more severe isolation, as they are unable to access the few methods of communication that people in Restrictive Housing can use to communicate with each other, such as yelling through doors and vents. The physical effects of isolation are also notable. Diminished access to sunlight for prolonged periods of time causes vitamin D deficiency, putting older adults more at risk for fractures and falls, which are leading causes of hospitalization and death. Restrictive Housing also limits physical activity, which is critical for older adults to maintain their physical health. Exercise, even in small amounts from walking between rooms, can serve as a preventative measure for conditions like hypertension, diabetes, arthritis, and heart disease. For adults who are already diagnosed with conditions for which routine exercise and movement is a first-line treatment, such as diabetes, hypertension, obesity, and histories of cerebrovascular and/or heart disease, Restrictive Housing can adversely affect the treatment and management of their conditions. Following the National Institute of Corrections and Bureau of Justice Statistics, we use age 55 as a benchmark for older adults in prison, in accord with research demonstrating that "unhealthy lifestyles and inadequate health care often accelerate the onset and progression of many chronic conditions associated with aging, and "old age in prison typically commences at ages 50 or 55 years."[25]

The percentage of individuals 55 or older held in Restrictive Housing on Q1 2019 and Q4 2021 remained similar in the DDU and Restrictive Housing.[13] In the DDU, those 55 and older made-up 2.46% in Q1 2019 and 6.98% in Q4 2021, with an absolute number of 3 for both quarters. Over the twelve-quarter period, the number of individuals held in long term confinement in the DDU ranged from 3 to 8. Similarly, for those held in Restrictive Housing on a disciplinary detention sanction (RH-DD) those 55 or older made-up 2.43% in Q1 2019 and 5.95% in Q4 2021. Over the twelve-quarter period the absolute number ranged from 10 to 26 persons, numbering 12 in Q1 2019 and 15 in Q4 2021.

Reasons for DOC's Use of Non-Disciplinary Restrictive Housing

The Department's quarterly reports indicate the reasons for use of non-disciplinary Restrictive Housing.[13] These reports are limited as they only give a snapshot on a specific day and time, and it is our understanding that these reasons can change overtime. Nevertheless, on average over the three-year period the vast majority of those in non-disciplinary Restrictive Housing were awaiting a disciplinary hearing, 45.66%, on average (52.43% if the average of 6.7% awaiting a DDU hearing is included), and on average 16.84% were held pending completion of an investigation.[13] These data are of limited utility as we are unable to determine the length of stay from these reports, or how long a person may have been on this status.

We observe from these limited reports that on average, 11.84% were held because they were "unwilling to accept a general population bed."[13] These are individuals who decline to leave Restrictive Housing to return to general population. This could be because they are afraid to return to their housing units due to conflicts, because their safety needs could not be verified by the DOC, because they are experiencing fear related to past trauma or existing behavioral health conditions, or because they prefer Restrictive Housing for other reasons. During tours of the DOC facilities, focus groups of correctional staff told RHOC members that because the CJRA had improved conditions in Restrictive Housing units, and had required that such units offer programs providing "earned good time" sentence reduction credits, they perceived that incarcerated people no longer feared, and even preferred, a Restrictive Housing placement to general population. Thus, many correctional staff felt Restrictive Housing was no longer punitive and had lost its deterrent value. Focus groups of incarcerated people, for their part, maintained that opportunities to earn "good time" sentence reductions were scarce in general population, and that in some places shared cells and chaotic conditions could drive people to seek Restrictive Housing. This was supported by at least one woman interviewed at MCI Framingham in October 2019, who stated she felt "Restrictive Housing was a break from the drama in general population." Thus, while 22-hour confinement seemed like a comfortable choice to some correctional staff, it appeared to incarcerated people to be a way out of the lack of access to earned good time and difficult conditions in general population, even if it imposed isolation.

A small but consistent number of incarcerated people with verified safety needs (sometimes informally called "protective custody") remained in Restrictive Housing, despite the CJRA's provision that, if "a prisoner needs to be separated from general population to protect the prisoner from harm by others, the prisoner shall not be placed in Restrictive Housing, but shall be placed in a housing unit that provides approximately the same conditions, privileges, amenities and opportunities as in general population."[26] Of note, a designation of verified safety needs is just a snapshot during a specific time, so it is impossible to determine the initial reason for placement that may have resulted in the necessary placement. This Committee has no data to support that initial placement in any Restrictive Housing unit was for this purpose.

Implementation of statewide protocols to respond to the COVID pandemic beginning in March 2020 appear to have impacted the use of Restrictive Housing. The DOC imposed movement limitations during the early days of the pandemic to limit the spread in the communal setting.

Perhaps due to the limited out of cell movement during this time, there were fewer non-disciplinary Restrictive Housing placements and, apparently, fewer verified safety needs.

Restrictive Housing Reviews

The CJRA provides that all persons in non-disciplinary Restrictive Housing shall have reviews every 90 days to determine whether they continue to pose an unacceptable risk that justifies continued confinement, with advance notice, an opportunity to participate, and, if they are not released, a written statement of reasons if they are retained in Restrictive Housing and behavior standards and program goals to help them gain release at their next review.[27] Even though the DDU was disciplinary Restrictive Housing while it was in operation, the law required that people held there receive similar reviews starting at 6 months and continuing every 90 days thereafter, though these reviews did not include an in-person hearing as did the reviews in non-disciplinary confinement.

The law also requires reviews for those with serious mental illness (SMI) and those held only due to a need for protection, starting at 72 hours and, for those awaiting a disciplinary hearing, every 15 days.[27]

According to the CJRA at G.L. c. 127 § 39A(a),

> a prisoner shall not be held in Restrictive Housing if the prisoner has a serious mental illness or a finding has been made...that Restrictive Housing is clinically contraindicated unless, not later than 72 hours after the finding, the commissioner, the sheriff or [a designee of either] certifies in writing: (i) the reason why the prisoner may not be safely held in the general population; (ii) that there is no available placement in a secure treatment unit; (iii) that efforts are being undertaken to find appropriate housing and the status of the efforts; and (iv) the anticipated time frame for resolution.[28]

The CJRA substantially broadened the statutory definition of SMI, and as such, the number of incarcerated people identified as SMI increased when the new definition went into effect.[29] This had several impacts, particularly for the Secure Treatment Units (STUs), referred to in §39A(a). These units were created to serve as alternative placements for people with SMI sentenced to DDU or other Restrictive Housing. The STUs predate the CJRA. The Secure Treatment Program (STP) opened in 2008, and the Behavior Modification Unit (BMU) opened in 2010. Both programs were designed with a narrower definition of SMI and were thus designed for persons who presumably had more serious mental health needs. The RHOC was informed during site visits that many people with SMI were held in Restrictive Housing because there were no available placements in Secure Treatment Units. This was attributed to long wait lists in the Secure Treatment Units. (In such cases, G.L. c. 127 § 39A(a) requires the facility superintendent or sheriff to "certify" that the person with SMI cannot be housed safely in general population, that there is no available placement in an STU and that efforts are being made to find an alternative to Restrictive Housing).

The CJRA requires reporting on the number of 90-day reviews held and the number of those resulting in release.[30] The percentage of reviews in non-disciplinary Restrictive Housing which resulted in release during the twelve quarters from January 2019 through December 2021, varied from 0.0 in one quarter (Q2 of 2019) to 22.5% in another (Q1 of 2021).[13] As presented in the quarterly data of those offered such reviews in the DDU during these twelve quarters, there were six quarters when none were approved for release, including the first three quarters of 2021.

Not only were the stakes higher for DDU reviews, but the reviews themselves did not appear to include an opportunity for in-person participation by the incarcerated person. People held in non-disciplinary Restrictive Housing were able to participate in their reviews in person, first at 30 days with a Correctional Program Officer (CPO) and then after 90 days with a Placement Review Committee, including one member each from security, program and mental health staff.[31] Those held in the DDU received their first review at six months and did not have any opportunity to participate in person. During the RHOC visit to MCI-Cedar Junction, administrators explained that the CPO only provided notice of the review, and presumably an opportunity to participate in writing.

It is worth noting that a significant number of reviews were reported as offered but not accepted; given that DDU reviews did not include an in-person hearing, it is hard to know precisely what was refused. Did these people refuse to allow administrators to consider them for release? Neither is it clear whether those refusing nevertheless were considered for release.

B. County Facilities

Level of use of Restrictive Housing

Among the counties that provided data for all 22-hour cell confinement, reliance on Restrictive Housing was higher in December 2021, at 4.6% of population, than it was when the CJRA went into effect in January 2019, when it was 4.0%.[4] There were large fluctuations up and down, with a gradual trend upward in usage until December of 2021.[32] This data is incomplete, however. As previously stated, many counties at different points of time maintained that the CJRA did not require reporting on 22-hour confinement and accordingly changed their reporting practices. The analysis only includes those counties that acknowledged and reported all Restrictive Housing of 22 hours or more in cell. Other counties stopped reporting data when they began allowing 2.25 or 2.5 hours daily out of cell. They are counted as "zero" RH.

- Counties not included because they use 22-hour confinement but do not report it: Plymouth County is not included because it never reported its 22-hour confinement, and Barnstable County is not included because it reported only its disciplinary confinement of 23-hours a day, but not its non-disciplinary confinement of 22-hour hours per day.[33] Hampshire, Norfolk, and Worcester counties are included only for the months that they reported their 22-hour confinement as Restrictive Housing.[34] Hampden County held people in cell for 23 hours a day, but during the RHOC's March 25, 2022, visit it became apparent that its numbers had

been understated because many people held in non-disciplinary Restrictive Housing had not been included in the reported numbers, and therefore it is not included.

- Counties which allow even slightly more than 2 hours a day out of cell to all in custody are included in the table as having no Restrictive Housing. This includes Franklin, Berkshire, and Suffolk Counties, which informed the RHOC that they allow a minimum of 2.25 hours out of cell daily.
- Dukes County does not hold anyone in Restrictive Housing due to its small size.

Aggregate data masks important differences between individual counties. Comparing Restrictive Housing usage rates in January 2019 with the December 2021 reported data for each county, most were similar or increased, with a couple of notable exceptions.[4] Franklin County declined from 1.39% to 0%. Elsewhere, however, trends were stable or upward. Essex climbed, from 3.06% to 4.99% and Bristol saw an increase from 4.40% to 5.96%. Middlesex and Suffolk counties rates of Restrictive Housing remained consistent in January 2019 and December 2021. Berkshire County started at 7.3% and, when it stopped reporting on those in Restrictive Housing for over 22 hours in March of 2021, had reached 19.7%. Some of the counties stopped reporting 22-hour confinement prior to December 2021. Worcester County Restrictive Housing was nearly the same in February 2020, Norfolk County declined from 1.97% to 1.05% in October 2020, and Hampshire had only a slight increase in its rate of RH, from 8.4% to 9.0% in January 2020. Counties also varied greatly in their baseline usage, both in absolute numbers and as a percentage of each county's population.

Detailed reporting on County use of Restrictive Housing

The Massachusetts Sheriffs' Association's (MSA) has provided annual reporting through calendar year 2023.[35] (Annual reporting for 2021 was very limited). There are several data limitations in this reporting that make it difficult to assess county information in the same way as one may assess DOC data as covered above. First, detailed reporting is required only once a year from the counties, so the aggregate reporting is more likely to capture multiple stays in Restrictive Housing by the same individual, and it is not possible to track changes over the course of each year. Second, only seven of the fourteen counties provided detailed data, and the others either do not consider 22-hour confinement to be Restrictive Housing, as they report they do not have confinement over 22 hours, or (in the case of Dukes County) do not have restrictive confinement.

In addition, variations in demographics across the seven reporting counties complicate comparisons among populations held in Restrictive Housing. Variations in the way that counties report racial demographics (factoring in both race and ethnicity) further complicate comparison and make it difficult to draw any conclusions about potential disproportionate impact of Restrictive Housing on BIPOC individuals in county custody across the state.

Finally, in response to the CJRA's requirements to report "the number of prisoners according to the reason for their Restrictive Housing," the DOC breaks down the numbers held in non-disciplinary Restrictive Housing according to the reason (e.g., verified safety needs, awaiting a disciplinary hearing, pending completion of investigation).[36] However, most counties reported only on discipline as a reason for Restrictive Housing, sometimes citing disciplinary code violations but not enumerating the numbers held without a disciplinary conviction and why.[35] All of the reporting counties use non-disciplinary Restrictive Housing – for persons accused of serious disciplinary offenses and awaiting a hearing, if nothing else – but we do not have detailed information, as we do with DOC, as to how many persons are held for which purpose.

The age demographics reported by the counties do reveal that people aged 25 and under make up between a quarter and a third of Restrictive Housing overall in the reporting counties, 27.1% in 2019 and 27.1% in 2020.[35] While the majority of stays in county Restrictive Housing were 15 days or less, in some instances young people were subjected to longer stays. The MSA's report indicates, a 24-year-old in Worcester County custody spent 237 days in Restrictive Housing in 2020, and a 21-year-old held there spent 120 days in Restrictive Housing that same year. Bristol, Essex, and Suffolk counties reported holding some people aged 25 or younger for between 100 and 153 days in 2019 and 2020. On the other end of the age spectrum, Suffolk County reported holding a 68-year-old for 80 days in 2019 and a 58-year-old for 125 days in 2020. This is not to single out any county, as we do not know practices in those counties that consider 22-hour confinement not to be Restrictive Housing, but to highlight the use of RH for specific cases. Norfolk County, which did not provide detailed reporting, has both a low rate of Restrictive Housing usage overall (as mentioned above), and reported during the RHOC site visit an average length of stay of 10 days.

The RHOC will continue to review the use of Restrictive Housing throughout the correctional systems that still acknowledge they have and use it, reviewing for compliance with the CJRA. Additionally, the Committee intends to review practices of all non-general population units used to mitigate risk in these systems and gather information regarding their use and conditions, unless it is confirmed that a particular unit is not Restrictive Housing in light of both letter and spirit of the law. One area the Committee is committed to reviewing more fully is understanding the risk individuals pose that require placement in Restrictive Housing, and how that could be mitigated in general population where possible.

VI. Restrictive Housing in Other Jurisdictions

The Legislature required that the Committee survey the use of Restrictive Housing in other states.[2] To that end, the RHOC created a sub-committee to survey the literature on national and international uses of Restrictive Housing and looked at three states – Ohio, Colorado, and New Jersey – that have undertaken to reform their Restrictive Housing policies and practices. We have also taken a close look at recent reform legislation in New York and considered international practices to understand the origins and evolution of Restrictive Housing and current best practices. We describe the international experiences and in other states in the United States, below. We begin with an overview, then look more closely at the experiences in selected jurisdictions.

A. United States Overview

Poor and incomplete data collection makes it difficult to know the exact number of people held in Restrictive Housing in U.S. prisons and jails. However, two important reports have been published in recent years (2022 and 2023) that shed considerable light on the subject. Throughout this section we sometimes use the terms "solitary confinement" or "isolation" to describe a jurisdiction's Restrictive Housing practice. We do so when that is what the practice is called or when that is how it is described by the source from which we are drawing the information about it.

The CLA and Liman Center 'Time in Cell' Report

The Arthur Liman Center for Public Interest Law at Yale Law School (Liman Center) and the Correctional Leaders Association (CLA) closely track data on the use of Restrictive Housing and Restrictive Housing legislative proposals and enactments. Their most recent 'Time in Cell' report, their fifth, was released in 2022.[37] It finds that prison systems report that fewer people are held in Restrictive Housing than in the past. The report suggests that change is probably the result of many corrections agencies revising their policies to put fewer people into isolation. Moreover, between 2018 and 2021, 22 states enacted legislation to curb the use of solitary confinement, and a few courts have held that specific forms of isolation are unlawful. Declining prison populations is another factor.

The report also examined the demographics of people held in isolation.[37] For example, the report found that Restrictive Housing continues to be used for people whom reporting jurisdictions define as having serious mental illness. Moreover, the report found that people of color were disproportionately placed in Restrictive Housing. This was especially true of female prisoners.

The data on the use of Restrictive Housing in the CLA and Liman report are current as of July 2021.[37] The survey of the states includes references to changes in Massachusetts law and describes the Falcon Report. Accordingly, the report informs the Committee's research and compliments our own limited state survey discussed elsewhere in this report.

The report defines "isolated individuals" as those held in a cell for an average of at least 22 hours per day for at least 15 continuous days.[37] According to CLA and the Liman Center, prison systems report that fewer people are held in Restrictive Housing than in the past. The report estimates that, as of July 2021, between 41,000 and 48,000 people were held in Restrictive Housing in U.S. prisons.

Indeed, in the summer of 2019, three states reported no people in Restrictive Housing – North Dakota, Delaware, and Vermont.[37] Additionally, two jurisdictions reported that they held fewer than ten people in Restrictive Housing. Ten jurisdictions responded that their women's prisons held no one in Restrictive Housing.

Of the thirty-five responding jurisdictions, the percentage of people in Restrictive Housing in prisons ranged from 0% to 14.8% of the prison population.[37] The median percentage of the population held in Restrictive Housing was 3.2%.

Between 2018 and 2022, 22 states and the federal government enacted laws regulating the use of isolation in the following ways:

Subpopulations

Many jurisdictions—more than 15 states and the federal government—have laws that limit or prohibit the use of Restrictive Housing for youth, pregnant people, or those with serious mental illness (although the definition of SMI varies from jurisdiction to jurisdiction).[37] The states include Arkansas, Colorado, Florida, Georgia, Louisiana, Maryland, Massachusetts, Montana, Nebraska, New Jersey, New Mexico, South Carolina, Texas, Virginia, and Washington.

Texas, Virginia, and South Carolina prohibit the use of Restrictive Housing for pregnant people or those who had given birth in the past 30 days unless there is a reasonable belief of flight risk or that the person will harm themselves, the fetus, or another person.[37] Other states that limit the use of Restrictive Housing for pregnant people or people who have recently delivered a child include Georgia, Maryland, Montana, New Jersey, Arkansas, and New Mexico. In Arkansas, for instance, an individual may not be placed in Restrictive Housing for 30 or more days if the individual is pregnant, has delivered a child within the previous 30 days, is breastfeeding, or is under a physician's care for postpartum depression or other postpartum conditions. New York prohibits segregated confinement for people who are pregnant, in the first eight weeks of the postpartum period, or caring for a child in a correctional institution. No state responding to the CLA and Liman survey reported a pregnant person in Restrictive Housing in July 2021.

In the past several years, at least six states adopted laws to address the use of Restrictive Housing for people with serious mental illness, a disability, or a substance use disorder.[37] For instance, Montana prohibits placement in Restrictive Housing for "behavior that is the product of [an] inmate's disability or mental disorder unless the placement is after prompt and appropriate evaluation by a qualified mental health professional," and Restrictive Housing must be "for the shortest time possible, with the least restrictive conditions possible." New Mexico's law requires that individuals with "serious mental disability" could be placed in Restrictive Housing only when it is necessary to "prevent an imminent threat of physical harm to the inmate or another person."[37] In such cases, Restrictive Housing is limited to 48 consecutive hours. Colorado prohibits the use of solitary confinement for individuals receiving evaluation, care, or treatment for substance use.

Of the states responding to the CLA and Liman survey, using their state's own definitions of SMI, twenty-eight jurisdictions identified a total of 1,138 seriously mentally ill people in Restrictive Housing.[37]

Transparency, Data Collection, and Oversight

According to the CLA and Liman Center, about a dozen jurisdictions have recently required data collection and reporting on the use of Restrictive Housing. In addition to Massachusetts, those jurisdictions are the federal government, Colorado, Kentucky, Maryland, Michigan, Minnesota, Nebraska, New Mexico, and Virginia.[37]

Time Out-of-Cell and Conditions of Confinement

As will be described more fully below, Colorado imposes obligations on prisons and local jails to provide people in Restrictive Housing with certain services that would be given to people in general population and to ensure access to exercise, visits, and legal assistance.[37] New York requires that people in segregated confinement be offered out-of-cell programming at least four hours per day, "including at least one hour for recreation."[37] Colorado and New York also place limitations on the amount of days an individual may be housed in isolated confinement.

Access to Items in Cell

Thirty states reported on access to items in Restrictive Housing cells.[37] Books and writing materials were available in 100% of the states. Other items include worksheets (90%), music players (60%), tablets (57%), TVs (53%), puzzles and board games (43%), videogames (13%), and the internet (1%). Except for videogames and internet, all these items were available to between 87% and 100% of people in general population.

The Solitary Watch/Unlock the Box Report

Another report, issued in January 2023, also using 2019 data, estimates that about 122,840 people in federal and state adult prisons and federal and local jails were placed in Restrictive Housing for 22 hours or more on a given day in mid-2019.[38] The report relies on self-reported figures from states and the federal government's Bureau of Justice Statistics as well as a survey sent to all U.S. jails by the Vera Institute of Justice, a nonprofit criminal justice advocacy group. Vera published a report on the use of Restrictive Housing in jails in 2021.[39]

The Solitary Watch report concludes that about 6% of the total U.S. prison and jail population was in Restrictive Housing at the time the data were collected, [38] compared to the 3.8% estimate in the CLA and Liman Center report.[37] In part the differences may be because the CLA and Liman reports do not include data from jails or federal prisons. As stated, the data from The Solitary Watch report are from a given day in 2019. The report lists Massachusetts prisons as having 269 individuals in Restrictive Housing – 3.4% of the prison population. That was, of course, before the DOC's changes to Restrictive Housing. It was also before the implementation of New York's HALT law,[40] discussed below.

In 2019, according to this report, only nine other states (Colorado, Connecticut, Delaware, Hawaii, Idaho, Maine, North Dakota, Vermont and Wyoming) had a lower percentage of state prisoners in Restrictive Housing (using the 22 hour in-cell definition) than Massachusetts.[38] The

number of individuals in jails is not broken down by state. However, the report says that 5.64% of persons in jails in the U.S. were in Restrictive Housing.

We turn now to the experiences in several key states. Not all this information is current to the date of the issuance of the RHOC report. The Committee gathered the information through interviews and research in 2021 and 2022. We have, however, included some more recent information when available from media reports and other sources. Throughout this section, we use the various names and terms for Restrictive Housing in the manner they are used by the other jurisdictions or as they are used in reports to which we refer.

B. Colorado

The Colorado Department of Correction (CDOC) initiated work to reduce Restrictive Housing by limiting the number of people placed in Restrictive Housing as early as 2011 under then Director of Prisons Tom Clements.[41] In 2013, a new Director of Prisons, Rick Raemisch continued the work, and it became a priority under his leadership to eliminate long term Restrictive Housing. Mr. Raemisch is a member of the Falcon Group team of experts working with the DOC. Implementing the reforms took time, a change in culture, policy revisions, piloting, evaluating and fine tuning. From 2013 to the fall of 2017 the CDOC successfully reduced RH from 90 days maximum to 60 days, then to 30 days and then to 15 days. During this time, they also prohibited the placement of seriously mentally ill (SMI) prisoners in RH. Staff we interviewed indicated that other than a change in culture and mindset there were no significant barriers to implementation and to the date of the interview there have been no significant changes to the reforms. By the fall of 2017, the use of Restrictive Housing was significantly limited.

(Effective in 2022, many of the same restrictions on the use of Restrictive Housing also apply to large county jails).[42]

Colorado began revising its use of Restrictive Housing in response to the nationwide the work being done to revise the American Correctional Association (ACA) standards for Restrictive Housing.[41] In 2013, Director Raemisch voluntarily spent 20 hours in Restrictive Housing to help himself understand its effect. He adopted the United Nations' Mandela Rules which limit solitary confinement (defined as 22 or more hours a day in cell without meaningful human contact) to no more than 15 days.[43] As of fall of 2017, placement in Restrictive Housing in the CDOC had been limited to 15 days.[41] Any need to house anyone beyond 15 days must be approved by the Director of Prisons.

At the time of our investigation, Restrictive Housing was defined as a person being confined to a cell for at least 22 hours per day.[41] Programs and good time credits are not provided to inmates in RH. The conditions of confinement afforded persons in RH include:[41]

- One person per cell
- Three complete sets of clean clothing per week
- Telephone Access: One 20-minute call within 24 hours of placement in RH. No restriction to attorney phone access.

- Visits: opportunity for social non-contact visits based on the facility's schedule. Attorney visits allowed by appointment only.
- Mail: can write and receive letters on the same basis as the general population.
- Exercise: one hour per day seven days per week.
- Showers: three times per week
- Canteen: limited to basic care and hygiene items (only). Max $10.00 per week.
- Property: limited to state issued clothing, hygiene items, stationary and limited personal items (wedding ring, eyeglasses, etc.).

The CDOC does not place females in Restrictive Housing.[41] Females requiring more structure based on their behavior are placed in a "classification unit." People deemed to have a serious mental illness (SMI) whose placement in general population poses a security risk are placed in a Residential Treatment Unit (RTU). The RTU program provides individuals with a mental health disorder and/or intellectual and developmental treatment needs individual and group therapy, educational programs, recreational therapy, and recreational activities to promote their program success and successful transition into the community or into a general population setting.

Alternatives to RH were established or modified by CDOC as part of the reforms. The CDOC established a Close Custody Special Management Control System. This system provides close custody designations that provide increased levels of housing, supervision, and control based upon the totality of risk presented, to maintain the safety of the public, DOC employees, volunteers, and other incarcerated persons. The system consists of three units:[41]

- Close Custody Management Control Unit/High Risk (MCU/HR): A designation that provides an increased level of housing, supervision, and control to maintain safety.
- Close Custody Management Control Unit/Comprehensive (MCC): A designation that provides the highest level of supervision and control to maintain safety.
- Close Custody Transition Units (CCTU): A temporary close custody unit that provides an increased level of security, supervision and control. Assignment to a CCTU is primarily used as a progressive management assignment for incarcerated persons who are either progressing from a Close Custody Management Control Unit or for newly arrived persons whose initial intake classification indicates a need for an increased level of supervision and control.

The type of behavior that warrants placement in this system are found in the CDOC Code of Penal Discipline and include:[41]

Murder (Attempt or Complicity)	Director of Prison to review and determine length of time
Manslaughter (attempt or complicity)	Up to 12 months

Kidnapping (attempt or complicity)	Up to 12 months
Assault on Staff (with intent to cause serious bodily injury)	Director of Prison to review and determine length of time
Assault on Offender (with intent to cause serious bodily injury)	Up to 12 months
Escape (attempt or complicity)	Up to 12 months
Engaging or Inciting a Riot	Up to 12 months
Arson	Up to 12 months
Possession of Dangerous Contraband	Up to 6 months
Possession of escape Paraphernalia	Up to 6 months

Consideration and review for placement into one of these units is conducted by an internal classification committee and begins immediately upon a removal from general population due to an allegation of one of the above identified incidents.[41] Other circumstances may warrant placement in one of these units. Such placement will be approved by the Director of Prisons. Placement beyond the above stated time frames requires a review from the Central Classification Committee and Director of Prisons. Out of cell time afforded in the MCC and MCC/HR units is four hours a day, in restraints. The CCTU affords six hours of out of cell time a day.

If mental health clinicians determine the behavior of a person in RHU or CCSMU may have been caused by a mental illness, or other significant mental impairment, the person will be referred to the Residential Treatment Program. [41] The program provides individual and group therapy, educational programs, recreational therapy and recreational activities to promote their program success and successful transition into the community or into a general population setting.

The Restrictive Housing review process has not changed significantly as a result of the reforms. Upon placement in Restrictive Housing, the person shall be screened by medical personnel and mental health staff to determine if there are any contraindications to placement. [41] Restrictive Housing may only be imposed as a condition of confinement for up to a maximum of 15 consecutive days for violation of the penal discipline code. All people will be reviewed by an internal classification committee once every seven days.

People can be placed in RH for temporary purposes for the following conditions:[41]

- Pending Reclassification/Transfer: A person may be removed from population and temporarily placed in Restrictive Housing pending reclassification and facility transfer in accordance classification rules.
- Pending Out of State Transfer: An inmate may be removed from general population and temporarily placed in Restrictive Housing pending review for out of state transfer.
- Protective Custody

Assignment to a Restrictive Housing unit for any of these reasons cannot exceed 15 consecutive days, unless approved in writing by the Director of Prisons. All people who are held longer than 30 days must have an out-of-cell mental health review. If it is determined the person has a serious mental illness, the Director of Prisons will be notified immediately.

The use of RH in the CDOC for the purposes of disciplinary detention continues. Data for length of stay and statistical information are available through their research division. In a February 2019 article Director Raemisch wrote stated that: "[t]he success [of the RH reforms] is visible in the data. When we started implementing the reforms, the perception was that violence and other negative incidents would spike as a result. But our data showed that a year into reforms, our overall assaults were at their lowest rate since 2006. Suicides and self-harm were also down."[41]

C. New Jersey

The New Jersey legislature enacted Restrictive Housing reforms in passing the Isolated Confinement Restriction Act, effective August 1, 2020.[44] The information contained in this section is based on a review of statutes, published news articles and interviews with key stakeholders involved in the policy development and implementation process of Restrictive Housing reforms in the state of New Jersey. We have updated our inquiries with information from as recently as October 2023.[45]

Reforms to Restrictive Housing in New Jersey started in 1986 when the American Friends Service Committee in Newark became aware of the Management Control Unit at Trenton State Prison.[46] The New Jersey Campaign for Alternatives to Isolated Confinement, a coalition of survivors and organizations, formed in 2012[47] and worked with two State Senators to draft the 2014 Isolated Confinement Restriction Act, which was eventually passed and signed into law by Governor Philip Murphy on July 11, 2019.[48]

In or about 2017, the New Jersey Department of Corrections took steps outside of a legislative mandate to proactively reform their use of Restrictive Housing.[49] Reforms were based on an internal review of policies and practices after recommendations were received from the American Correctional Association (ACA) and the Association of State Correctional Administrators (ASCA). Changes made during this time were similar to the reforms included in the Massachusetts CJRA.[1]

During New Jersey's development and implementation of non-legislative reforms, the Department of Corrections created an internal committee with a wide variety of concentrations represented to inform the development of their internal policies as well as identify and address potential implementation barriers.[49] For example, meetings were held with the correctional officers' union to promote dialogue and involve them directly in the change process. This was perceived to promote buy in from line staff and facilitate the implementation of new practices. Reports indicated that more restrictive, or higher security, facilities had an easier time implementing changes (New Jersey did not have Restrictive Housing in every facility; only 5 out of 12 facilities). However, all facilities could access Restrictive Housing through their internally operated transportation system which is able to quickly move large numbers of people.

In 2019, the New Jersey legislature passed additional reforms which sought to further curtail the use of Restrictive Housing (see below for details about this process and the governing statute). As noted above, in New Jersey there had been a social and political movement against Restrictive Housing for over a decade. In the roughly 10 years prior to the passage of the 2019 legislative reforms there had been several iterations of proposed legislation to reform Restrictive Housing which did not pass. However, in 2019, with a new and popular legislative champion, the bill passed.[48]

Some of the reforms from the Isolated Confinement Restriction Act include: [48]

- Isolated confinement may only be used in cases where there is reasonable risk of harm to self or others, and less restrictive measures would not be sufficient.
- The correctional facility must justify use of isolated confinement by clear and convincing evidence. Isolated confinement may not be used for non-disciplinary reasons, except for facility-wide lock downs, emergency confinement, medical isolation, and protective custody.
- A person must receive a medical and mental health examination, conducted by a clinician, before being placed in isolated confinement. (See Section 7, "Procedural and Administrative Changes to the Restrictive Housing Process," below.)
- Procedures and reviews providing timely, fair, and meaningful opportunities for an incarcerated person to contest isolated confinement must be made available. (See Section 7, "Procedural and Administrative Changes to the Restrictive Housing Process," below.)
- The facility administrator will make the final decision to place a person into or remove a person from isolated confinement, except in cases involving medical isolation.
- A person in isolated confinement will receive daily clinician evaluations (in a state correctional facility) and medical evaluations at least once a week (in a county correctional facility). If an evaluation indicates the person is a member of a vulnerable population, the person "shall be immediately removed from isolated confinement to an appropriate placement."
- No one "shall be placed in isolated confinement for more than 20 consecutive days, or for more than 30 days during any 60-day period," and "[c]ells or other holding or living space used for isolated confinement are to be properly ventilated, lit, temperature-monitored, clean, and equipped with properly functioning sanitary fixtures." The Isolated Confinement Restriction Act prohibits isolation of anyone who:
    - is 21 years of age or younger;
    - is 65 years of age or older and has a disability based on a mental illness, a history of psychiatric hospitalization, or has recently

exhibited conduct, including but not limited to serious self-mutilation, indicating the need for further observation or evaluation to determine the presence of mental illness;
- has a developmental disability;
- has a serious medical condition which cannot be effectively treated in isolate confinement;
- is pregnant, is in the postpartum period (defined as 45 days after childbirth), or has recently suffered a miscarriage or terminated a pregnancy;
- has a significant auditory or visual impairment; or
- is perceived to be lesbian, gay, bisexual, transgender, or intersex.

However, members of the populations listed above may still be placed in isolated confinement under the following circumstances: "(1) [t]he facility administrator or designated shift commander determines that a facility-wide lock down is required"; "(2) [t]he facility administrator determines that an inmate should be placed in emergency confinement"; "(3) [a] clinician, based on a personal examination, determines that an inmate should be placed or retained in medical isolation"; or (4) "[t]he facility administrator determines that protective custody is warranted." [48]

That said, a person "shall not be placed in isolated confinement or in any other cell or other holding or living space, in any facility, with one or more other incarcerated people if there is reasonable cause to believe that there is a risk of harm or harassment, intimidation, extortion, or other physical or emotional abuse to that or another incarcerated person in the placement." [48]

The law also mandates the establishment of "less restrictive interventions to isolated confinement, including separation from other inmates; transfer to other correctional facilities; and any non-isolated confinement sanction[s]."[48] However, "restrictions on religious, mail, and telephone privileges, visit contacts, or outdoor and recreation access shall only be imposed as is necessary for the safety of the inmate or others, but shall not restrict access to food, basic necessities, or legal access." [48]

Procedural changes resulting from the 2019 reforms include:

- "[A]n inmate shall not be placed in isolated confinement before receiving a personal and comprehensive medical and mental health examination conducted by a clinician, or, in a county facility, by a member of the medical staff within 12 hours of confinement and the clinical examination shall be conducted within 48 hours of confinement, but if staffing levels require, the period for conducting a clinical examination may be extended to 72 hours of confinement.
- Except [under facility-wide lockdown], an inmate shall only be held in isolated confinement pursuant to initial procedures and reviews which provide timely, fair and meaningful opportunities for the inmate to contest the confinement. These include the right to an initial hearing within 72 hours of placement and a review every 30 days thereafter. the right to appear at the hearing; the right to be

represented at the hearing; an independent hearing officer; and a written statement of reasons for the decision made at the hearing.

- An inmate shall not be placed or retained in isolated confinement if the facility administrator determines that the inmate no longer meets the standard for the confinement.
- A clinician shall conduct a mental health and physical health status examination for each inmate placed in isolated confinement on a daily basis, in a confidential setting outside of the cell whenever possible, to determine whether the inmate is a member of a vulnerable population; however, in a county correctional facility, an inmate in isolated confinement shall be evaluated by a member of the medical staff as frequently as clinically indicated, but at least once per week. An inmate determined to be a member of a vulnerable population shall be immediately removed from isolated confinement and moved to an appropriate placement.
- An inmate shall not be placed in isolated confinement for more than 20 consecutive days, or for more than 30 days during any 60-day period.
- A correctional facility shall maximize the amount of time that an inmate held in isolated confinement spends outside of the cell by providing, as appropriate, access to recreation, education, clinically appropriate treatment therapies, skill-building activities, and social interaction with staff and other inmates.
- An inmate in a State correctional facility shall not be directly released from isolated confinement to the community during the final 180 days of the inmate's term of incarceration, unless it is necessary for the safety of the inmate, staff, other inmates, or the public. An inmate in a county correctional facility shall not be directly released from isolated confinement to the community during the final 30 days of the inmate's term of incarceration, unless it is necessary for the safety of the inmate, staff, other inmates, or the public.
- An inmate shall not be held in isolated confinement based on the inmate's 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." [48]

These statewide reforms were technically effective August 1, 2020. However, due to the COVID-19 pandemic there was a delay in their full implementation, although some partial implementation did occur.

According to the New Jersey Department of Corrections, the close custody units at the time the RHOC inquired were named as follows:

- Pre-Hearing Disciplinary Housing
- Management Control Unit
- Restorative Housing Unit
- Adjustment Unit
- Protective Custody Unit
- Temporary Administrative Housing Unit

- Investigative Housing Unit
- Emergency Confinement Unit

It appears that the Restorative Housing Units house the majority of incarcerated people subject to close custody. Of these eight units, at the time of our contact with New Jersey officials,

- length-of-stay reforms (15 days placement not to exceed 30 days in a 60-day period) have only been implemented in and proposed to apply to one of the eight units (the Adjustment Unit), and
- vulnerable population exclusions have only been implemented and proposed to apply to four of the eight units

This complex system of specialized units complicates oversight and meaningful reform due to the large number of exceptions to the statute and the complications of implementing changes over multiple sites with different populations, according to an official with whom we talked.

Simultaneous to the implementation of the 2019 legislative reforms, the New Jersey Department of Correction reached a settlement of nearly $21 million with 20 women incarcerated at Edna Mahan Correctional Facility for Women. The suit was precipitated by sexual misconduct and other atrocities committed by two dozen guards in two days, January 11 and 12, 2021, on women in the Restorative Housing Unit.[50] Subsequently, several state legislators publicly called for the resignation of Corrections Commissioner Marcus Hicks. Advocates and formerly incarcerated people identified lack of oversight, lack of accountability, and a specific culture of complicity among prison guards as barriers to change within the prison.[51] In 2021, New Jersey's Governor announced the prison would close.[52] However, the prison remains open, subject to implementation of a settlement agreement with the Department of Justice.[53]

Notable Subsequent Modifications to the Original Reforms

While state law stipulates that no one "shall be placed in isolated confinement for more than 20 consecutive days, or for more than 30 days during any 60-day period," sanctions of up to 365 days per incident are still possible in a newly proposed restorative housing unit.[54] NJDOC explained that it "believes five to 15 days will be sufficient for disciplinary purposes and may be followed by added sanctions in the Restorative Housing Unit based on the severity of the offense."[55]

There is also a new one-time drug diversion program proposed as a less restrictive alternative to isolated confinement. The NJDOC has described the program as "a 60-day intervention pathway for drug rehabilitation and related behavioral modification."[55]

Reform Outcomes

As previously noted, the 2019 Isolated Confinement Restriction Act went into effect August 1, 2020, during the COVID-19 pandemic which affected many aspects of corrections operations, including full implementation of this statute. While no policy evaluation data were available at the time of our inquiries, inspection of the most recent, publicly available NJDOC

population statistics at the time showed a 47% drop in the number of men in administrative segregation at Northern State Prison from 465 men on January 1, 2019, to 248 men on January 1, 2020. While there are different possible causes of this drop, one interpretation is that the statute leads to less people in isolated confinement.

*New Jersey Department of Corrections Administrative Segregation Male Population 2011-2020**

Notwithstanding this decline, direct accounts from people currently incarcerated in New Jersey suggest that meaningful implementation of the Isolated Confinement Restriction Act has not occurred at the Edna Mahan Correctional Facility and South Woods State Prison. For example, on her personal blog, Demi Minor, a transgender woman and a member of a vulnerable population as defined by the Isolated Confinement Restriction Act, reported to be serving a 120-day sentence in the Restorative Housing. On August 20, 2020, she wrote:

> a last minute attempt seven days before the new law's effective date stated to all inmates that it would be renaming solitary [as] "Restorative Housing Unit". The department rolled out a new disciplinary program that is more harsh and now brings back forms of solitary that were abolished years ago. NJDOC has continued to operate these isolation units claiming that because they changed the name from "Administrative Segregation" to "Restorative Housing Unit" inmates are not in solitary. As I write this to you I am doing 20-23 hours per day in the cell sanctioned to solitary for 120 days.[56]

An April 2021 news report described the situation of a man incarcerated in a restricted housing unit at South Woods State Prison in Bridgeton who reported that the legally required four hours of out of cell time was "very hit or miss" in its availability and implementation.[57]

These complaints have continued through 2023. As has been the case in some other states, incarcerated people and their advocates have complained that NJDOC has not faithfully implemented the reforms. According to critics, the units are always full, required time out of cell is not being observed, mental health services are not available, restraints are over-used, and programming is not being provided.[57] In response to the complaints, the New Jersey Prison Ombudsperson conducted a study. A report issued in October 2023 confirms some of the complaints. For instance, the Ombudsperson found that 76% of those on Restorative Housing Unit status reported being provided less than an hour out of their cells per day. Seventeen percent reported being provided one to two hours outside of their cells. Five percent reported more than two but fewer than four hours, and two percent reported being provided more than 4 hours outside of their cells.[58]

The Ombudsperson pointed out that because a significant number of prisoners in the Restorative Housing Unit has engaged in assaultive behavior, security precautions were necessary for safety.[58] Policies dictate that they be handcuffed and escorted by two officers whenever a person comes in direct contact with staff. If a person is taken off the housing unit for an appointment, they must be strip searched. The logistics of moving people takes time and personnel.

Moreover, the facility design and physical space limitations impose additional hurdles to out-of-cell time.

One advocate told the HuffPost that New Jersey is "the canary in the coal mine." The failure to implement the meaningful legislative changes, she said, should serve as an important lesson to other states that have passed or are looking to pass laws to restrict the use of solitary confinement.[57]

In addition to the barriers noted by the Ombudsperson, the impact of COVID-19 on correctional operations likely explains some of the delays in the implementation of reforms. Given that the law has not been fully implemented, it is too early to understand its full impact, although some preliminary data suggests a potential reduction in the use of Restrictive Housing at certain facilities after the official implementation date. However, at the time of our inquiries, there was already a downward trend in the use of Restrictive Housing in these facilities, which could be attributable to prior efforts to reduce the use of Restrictive Housing.

D. Ohio

The RHOC looked at several policies and statutes governing the use of Restrictive Housing in Ohio. Ohio has undertaken some reforms of its use Restrictive Housing, especially by creating alternative units. According to our review, Ohio has several stages of housing used to respond to pending investigations, transfers and, after a disciplinary hearing, placement imposed by a hearing officer. "Restrictive Housing," which may be short-term (30 days or less) or long-term (more than 30 days) is the most restrictive form of housing, because it requires an inmate to be confined to a cell at least twenty-two hours per day.[59] "Limited privilege housing," which has been designed as an alternative to Restrictive Housing, is less restrictive and is considered the "default" placement.[60] Limited privilege housing terms may be shorter than those in Restrictive Housing, there is more time out of cell, more possessions are allowed, and more programming is available. It may also be used as a step-down from Restrictive Housing. An inmate may only be sent to Restrictive Housing if it is determined that limited privilege is insufficient to manage the safety and security requirements of the inmate.[59]

Prior to placement into Restrictive Housing, for any reason, healthcare personnel must complete a screening to determine if the person is at imminent risk for serious self-harm, suicide, requires emergency medical care or if the inmate is exhibiting symptoms of a Serious Mental Illness.[59] If any of these conditions or needs are detected an appropriate health/behavioral care professional conducts appropriate assessment and treatment prior to placement into Restrictive Housing. The assessment and treatment may also result in the diversion of the inmate.

If the placement in Restrictive Housing extends beyond twenty-one days, the facility must ensure that the inmate is not seriously mentally ill.[59] In the event the inmate is seriously mentally ill, other arrangements to manage an inmate in limited privilege housing, an appropriate mental health unit or other appropriate placement that is not a Restrictive Housing must be made.

An inmate may be placed in a "limited privilege housing" assignment during an investigation for no more than seven business days except in exceptional circumstances.[60] The time may be extended another seven days. After a hearing, the inmate may be placed in limited privilege housing for up to seven calendar days for a first offense, up to 14 days for a second offense, and up to 21 days for a third offense.[61] Up to 90 days may be imposed by further offenses. The offenses are measured in the course of a prisoner's annual classification period. The inmate may be released before the end of the term.

Inmates placed in a limited privilege housing assignment shall receive, at a minimum, the following privileges:[60]

- Personal hygiene articles stationery supplies including writing supplies, one legal kit, and one personally owned deck of playing cards.
- Mail and kite (a written request for something, often medical care) privileges on the same basis as inmates in general population.
- A reasonable amount of personally owned soft cover books, religious books, personally owned law books/materials, one current newspaper and magazine by subscription only.
- Access to legal materials and services.
- Access to medical and/or mental health services, more than two hours of out of cell time per day, no less than seven days per week, which shall include the opportunity for a minimum of one hour of exercise per day outside of the cell at indoor and/or outside recreation as facility design, security, and safety considerations permit.
- Showers seven times per week.

In conversations with Ohio Department of Rehabilitation and Correction leadership, we learned that there were several barriers to implementation of the alternatives to Restrictive Housing, including corrections officers' willingness to accept changes to Restrictive Housing, and the need for additional training of staff. The feeling among some staff and leadership was that some inmates, especially at the most secure facility, are not appropriate for these changes.

E. New York

Forms of Restrictive Housing in New York have been the subject of several important class action lawsuits and at least two statutory reforms. In 2021, the Assembly enacted, and the Governor signed the Humane Alternatives to Long Term Solitary Confinement Act (HALT),[40] almost certainly the most sweeping legislative reform yet in the United States. The law become effective April 1, 2022. The HALT Act's various provisions include:[40]

- Limitations on the use of segregated confinement which it defines as any form of cell confinement lasting more than 17 hours per day. Segregated confinement may not be used for more than 15 consecutive days. After 15 days the prisoner is entitled to additional time out of the cell and rehabilitative programming.

- Creation of residential rehabilitation units as an alternative rehabilitative measure and an alternative to segregation.
- Prohibition of segregated confinement for special populations for any length of time. That includes youths under 21 years of age; persons 55 or older; anyone with a disability; pregnant women and those who have recently given birth or are caring for children.
- Prohibition of the denial of services, treatment, or basic needs for those in segregated confinement. It mandates additional staff training and provides for additional due process protections at disciplinary hearings. The corrections department, DOCCS, is required to publish reports on the use of segregated housing.

The HALT law is still new and is being implemented. However, there appears to be push back from both corrections officers and incarcerated people. The CO's union is campaigning to repeal the law alleging that violence has increased in state prisons since its implementation. The union claims that Inmate-on-staff violence has increased approximately 25%, while inmate-on-inmate violence has climbed 40%.[62]

On the other hand, incarcerated people and their advocates have complained that the state is not complying with the provisions of the HALT law. According to corrections department statistics some people are being held in Restrictive Housing for longer than the 15 days permitted by the new law.[63] Moreover, advocates and incarcerated people have complained that prisons are not adhering to the requirements for the Residential Rehabilitation Units which replaced Restrictive Housing. These units are supposed to provide six hours a day out of cell and programming including mental health treatment and recreation. According to critics, the units do not provide programming and merely operate as an extension of Restrictive Housing.

The New York Offices of the Inspector General issued a report of an independent evaluation of the first two years of implementation in August 2024. The I.G. acknowledged that NYDOC had implemented some of the reforms, noted some inadequacy, and complained that inadequate recordkeeping and antiquated data systems made investigations of some important areas of implementation very difficult.[64]

Conclusions about Experiences in other States

Massachusetts has joined with several other states in initiating reforms to the use of Restrictive Housing for disciplinary and other purposes. The current reforms in DOC facilities, driven first by litigation, then by legislation, and then even further by DOC's embrace of the recommendations in the Falcon Report, have some similarities to reforms elsewhere. In other important respects, however, the Massachusetts reforms go further and are more ambitious than those in other states. As was the case in Colorado, it is important that many of the reforms here have been initiated by DOC administrators.

There are lessons to be learned from others' experiences. The complaints from prisoners in New York and New Jersey, for instance, are similar to those raised in October 2023 by some Massachusetts incarcerated people and their advocates.[65] We also have observed here and in information we have gathered from other jurisdictions, that correctional staff have a critical role

to play in the successful implementation of Restrictive Housing reform. Support and "buy in" from line staff are essential. In addition, we have seen here and elsewhere that implementation can be complicated by limitations imposed by aged physical plants as well as unanticipated events like the pandemic. DOC leaders should be aware of and try to learn from experiences in other states.

We have discovered fewer reforms nationally in jails. Legislation in Colorado has extended reforms there to jails. The Massachusetts CJRA provisions on Restrictive Housing, of course, apply equally to DOC and country facilities.[1 5]

F. The International Experience

Although "Restrictive Housing" has a precise statutory definition in Massachusetts, "solitary confinement" is a far more common usage internationally. Accordingly, we will most often use the internationally recognized (if not uniformly defined) term when describing international law and individual nations' use of the practice.

We begin with a description of the international law on solitary confinement and then describe its use in some countries. We limit our survey to the use of solitary in the context of incarceration as a part of criminal justice systems. Although extreme isolation or solitary conditions may be used in some places attendant to enforced disappearances, secret detention, and with prisoner of war and political prisoners, we do not look to those uses here.

International Human Rights Law and its Relevance to U.S. Practices

Put a bit simplistically, international law is the body of legal rules, norms, and standards that apply between and among sovereign states and other entities. The range of subjects covered by international law is broad. Originally concerned with questions of war, peace, and diplomacy, it now includes, among other subjects, human rights, economic and trade issues, and international organizations – the human rights laws are the most pertinent here.

International law provides a level of certainty and a set of procedures in international relations. Although there are United Nations-affiliated and regional courts and committees that may adjudicate some disputes, international human rights law is a system that is sustained largely by a sense of enlightened self-interest. That is, states that fail to comply with international rules may invite reciprocity, suffer a decline in credibility and influence, or find it difficult to hold other nations to the agreed to norms. International human rights law is perhaps unique in international law because of the extent to which it is influenced significantly by ethical principles and concerns.

Although human rights treaties (such as those to combat the slave trade) existed before World War II, since the end of the War, the United Nations has been the most important vehicle for the development of international human rights law. The first very broad and very significant statement about human rights by the world's nations was the Universal Declaration of Human Rights, adopted unanimously by the General Assembly in 1948.[66] Since then, there have been numerous human rights conventions and declarations adopted by the General Assembly and

ratified by nations, including those on the rights of women (1979),[67] freedom from racial discrimination (1965),[68] the rights of children (1989)[69] and the rights of migrant workers (1990).[70]

Several international conventions address the rights of prisoners and detainees. The Convention on the Rights of Persons with Disabilities (CRPD) (adopted 2006, in force 2008), includes provisions on criminal justice, imprisonment, and institutionalization. The International Covenant on Civil and Political Rights (ICCPR) (in force 1976, Optional Protocol in force 1991), includes provisions on prison conditions and elimination of the death penalty. The most relevant international convention to the RHOC's work is the Convention Against Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment (Convention Against Torture) (in force 1984, Optional Protocol 2002). Most of these conventions address solitary confinement indirectly, by the strong implication of broad principles.

Regional organizations, such as the Council of Europe and the Organization of American States (of which the U.S. is a member), have also developed bodies of regional international law which address prisons and prison conditions.

The UN and the regional bodies have courts where disputes about a nation's compliance with a treaty may be heard. Under some human rights conventions, many nations which ratify the conventions agree to have their compliance monitored by committees of experts under the auspices of the UN Human Rights Council and to have complaints about non-compliance adjudicated by that committee.

The impact of international human rights law is restrained in the United States because we often do not ratify human rights treaties. For instance, about 90% of UN member nations have ratified the CRPD; the U.S. has not. The U.S. and Somalia are the only UN members not to ratify the Convention on the Rights of the Child. Even when we do ratify, we often attach conditions, called "reservations" or "declarations." These are usually statements of the ratifying nation's understanding of a provision of the treaty or its reservation of a right despite the language of the treaty. [71] This is a common practice for other nations as well. Likewise, the U.S. may not sign and/or ratify Optional Protocols even when we have ratified the underlying treaty. This is true, for instance, of the Convention Against Torture. (Optional Protocols usually establish a complaint mechanism through which a U.N. body may hear and adjudicate complaints.) Unlike many other countries, the U.S. often does not recognize the jurisdiction of the international courts. For instance, unlike 123 other countries, the U.S. does not participate in the International Criminal Court which hears human rights cases including war atrocities. The U.S does participate in proceeding in the International Court of Justice (The World Court) but does not recognize its plenary authority over the U.S.[72]

Also, unlike some countries, U.S. law regards those treaties to be "not self-executing," which means they cannot be enforced in U.S. courts absent implementing legislation. However, U.S. judges occasionally look to international treaties and conventions to help interpret U.S. laws this can be especially important in interpreting the meaning of the Constitution's Eighth Amendment which bars "cruel and unusual punishment." The often-repeated test is that the amendment "must draw its meaning from the evolving standards of decency that mark the progress

of a maturing society."[73] International standards and practices, therefore, may be one measure of the scope of the Eighth Amendment's protection. For instance, the Supreme Court cited to the Convention on the Rights of the Child in support of its decision in Roper v. Simmons, which held that the death penalty is unconstitutional when applied to minors.[74]

International use of solitary confinement prior to the relevant modern treaties

Isolation as a cornerstone of incarceration spread internationally in the early 1800s.[17] The practice was influenced by models developed at Auburn, New York and by the Pennsylvania prison system. The Auburn system, which spread quickly throughout the US, permitted prisoners to work together during the day but without communication. They were isolated in silence in their cells when not working or attending church. The Pennsylvania system, which was adopted through Europe and in other parts of the world, required prisoners to be in their cells 23 hours a day with one hour of yard time. They might be let out of cell to meet with a Chaplin. This was large scale solitary confinement by any measure. Officials believed then that isolation would encourage prisoners to turn their thoughts inward and to God and would result in their return to society as morally cleansed Christians.

As the adverse health and other consequences of the isolation models became more obvious, their wide-spread use faded in many places, particularly in some states in the U.S. However, the Pennsylvania model continued well into the twentieth century in Belgium, Denmark, Sweden, Holland and Norway.[75]

Beginning in the 1800s and for decades, international conferences of penal officials endorsed, or at best failed to condemn these practices. The U.S. Supreme Court criticized solitary confinement in 1890,[76] but it was not until 1930 that an important international body began to question the practice. In that year, the Global Penitentiary Congress in Prague recommended that solitary confinement be used only for short periods and that medical care be available.[77] The suggested reforms were not widely implemented before war approached and the international group came under the control of the Nazis.

After World War II, conditions of imprisonment came within the scope of the UN's human rights initiatives and in some treaties. Human rights treaties became more common in and after the 1960s and some standards addressed the rights of persons deprived of their liberty. These conventions, which address conditions of confinement in general terms have provided the foundation for more specific international standards about solitary confinement.

The International Covenant on Civil and Political Rights (ICCPR)

The 1966 ICCPR, at Article 10.1,[78] states that "All person deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person." Article 7 prohibits cruel or inhumane treatment.[79]

The ICCPR is one of the foundations for the Istanbul Statement and the Mandela Rules on solitary confinement that will be summarized below.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

Article 1(1) of the Convention defines "torture" to mean "any act by which severe pain or suffering whether physical or mental, is intentionally inflicted on a person for such purposes as … punishing him for an act he or a third person has committed or is suspected of having committed, … when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions." [80]

Moreover, Article 16(1) requires that nations "shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity." [81]

European Convention on Human Rights and Fundamental Freedoms and Protocol

This convention prohibits torture and inhumane and degrading treatment of incarcerated people.[82]

Statements of rules based on the treaties

There are several important statements and sets of rules created by various UN entities that are based on interpretations of the treaties and conventions discussed above. The most recent and relevant statements from the UN on solitary confinement are contained in the **Nelson Mandela Rules**, adopted unanimously by the General Assembly in 2015.[83] The Rules define solitary confinement as "the confinement of prisoners for 22 hours or more a day without meaningful human contact."[84] Solitary confinement may only be imposed in exceptional circumstances, and solitary confinement of more than 15 consecutive days is regarded as a form of torture. The use of solitary with prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures is prohibited.

The Nelson Mandela Rules reinforce the human rights principles contained in several conventions, including the recognition of the absolute prohibition of torture and other cruel, inhuman or degrading treatment or punishment. They are intended to provide guidance to national prison administrations for persons deprived of their liberty.

Other standards, the so-called **Bangkok Rules**, prohibit the use of disciplinary segregation with pregnant women, women with infants and breast-feeding women.[85] These rules are incorporated into the Mandela Rules [86].

An international meeting of mental health and human rights experts in 2007 in Istanbul concluded that it had been convincingly documented that solitary confinement may cause serious

psychological and sometimes physiological ill effects.[87] Concluding that research shows that between one third and as many as 90 percent of prisoners experience adverse symptoms in solitary confinement, they issued the **Istanbul Statement** on solitary confinement. They recommended that solitary confinement should be absolutely prohibited (a) for death row and life-sentenced prisoners by virtue of their sentence; (b) for mentally ill prisoners; (c) for children under the age of 18; and (d) when intentionally used to apply psychological pressure on prisoners which was deemed to be torture. The Istanbul Statement was attached to reports to the United Nations General Assembly from the Special Rapporteur on Torture and was one of the justifications for his findings that solitary confinement can amount to a form of torture.[88]

Interpretations of Treaties by UN and Regional Human Rights Courts and Committees

The UN

The UN Human Rights Committee, several committees charged with monitoring the treaties, and several Special Rapporteurs have issued reports of investigations or written decisions on complaints concluding that any use of solitary confinement except in extreme circumstances for no more than 15 days, should be prohibited. In addition, they have concluded that prisoners placed in solitary should have the right to legal counsel, the right to judicial review, and access to adequate medical monitoring and treatment.[89]

For instance, the Human Rights Committee has interpreted the ICCPR to mean that "persons deprived of their liberty [may not] be subjected to any hardship or constraint other than that resulting from the deprivation of liberty." [90] Likewise, the Committee has said that "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by Article 7" of the ICCPR, which prohibits cruel or inhumane treatment.[91]

The Council of Europe

The European Commission on Human Rights condemned severe solitary confinement as a form of inhumane treatment in 1978. It said, "[c]omplete sensory isolation coupled with complete social isolation can no doubt ultimately destroy the personality; it constitutes a form of inhumane treatment which cannot be justified by the requirements of security."[92]

The European Court of Human Rights, which replaced the Commission in 1988, has reiterated this view.[93] Nevertheless, in its adjudication of cases challenging the practice as a violation of the European Human Rights Convention, the Court has concluded that prohibition of human contact for security, disciplinary, or protective reasons does not alone amount to inhumane treatment. But particular factors such as the conditions, regime, duration, the socio-psychological make-up of the person, the reason for the isolation, may cause the isolation to be inhumane treatment.

The European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment (CPT) has unlimited access to all places of detention in the jurisdiction of member states.[94] In 2011, the CPT called on the nations to ensure that solitary confinement is

used to the absolute minimum extent and to ensure it meets what the CPT called the PLANN test: that is, that it is proportional, lawful, accountable, necessary and non-discriminatory.[95]

How some other countries use solitary confinement

This brief survey is *not* intended to be comprehensive. We have selected a handful of countries, from four continents, that are in the midst of some efforts to reform the use of solitary confinement. Interested readers seeking more information are directed to what we have found to be the most comprehensive and useful world surveys of solitary confinement, including in the U.S: Seeing into Solitary: A Review of the Law and Policies of Certain Nations Regarding Solitary Confinement of Detainees.[96] This 50-page report was prepared in 2016 by a world-wide network of pro bono attorneys under the auspices of the Vance Center for International Justice and the law firm Weil, Gotshal and Manges, LLP for Juan E. Ménendez, then the UN Special Rapporteur on Torture.

Global Prison Trends 2021 Special Focus: Prisons in Crisis. This comprehensive and more current report on many aspects of prisons globally includes a section on solitary confinement. The report is written by Penal Reform International and the Thailand Institute of Justice.[97]

Unlike our descriptions below, the Vance Center/Weil report presents information in the aggregate.[96] Penal Reform International includes summaries of the situations in several nations.[97] Before describing what we have learned about individual countries, we summarize a few things that Vance Center and Weil reported about the 26 nations they studied. [96]

Typical international rules governing solitary confinement

Limitations on who may be placed in solitary confinement. Fifteen of the countries surveyed had gender or features related to gender limitations on the use of solitary. [96] For instance, Guatemala, Kyrgyzstan, Russia, Argentina, Venezuela, the Czech Republic, and Uruguay prohibit segregation of pregnant women. Most of the same countries and others prohibit isolation of women who are lactating or have very young children. England and Poland have more universal limits on segregation of women.

Uganda bans solitary for prisoners with physical illnesses. [96] South Africa, Turkey, Uruguay, Hungary, France and Finland postpone solitary during physical illness. Several countries have provisions regarding prisoners with mental illness. Solitary may be banned entirely (e.g., Uganda and Argentina); banned if solitary will exacerbate the mental illness (e.g., Austria and Guatemala); postponed; or provided in special units. Sexual orientation limitations are apparently rare.

Time limits. Most of the surveyed nations have limits on how much time a prisoner may spend in segregation. [96] The limits often vary depending on the purpose of the confinement. Some of these limits are the most dramatic we have discovered in our research.

Some nations, for instance Sweden, Norway and South Africa, as we describe below, do not allow solitary confinement as a disciplinary sanction. [96] Norway limits disciplinary segregation to 24 hours. Most other nations prohibit disciplinary segregation to a maximum of 30 days. However, most also allow for renewal or expansion under some circumstances.

Most nations limit administrative segregation to 15 days or fewer. [96] Germany limits administrative segregation to 24 hours; Japan to 72 hours; Norway to 6 days; Brazil, Hungary and Uruguay to 10 days.

Many countries used solitary confinement as a way to deal with the Covid pandemic.[97] Prison Reform International suggests that such measures actually increased the spread of the virus as prisoner were reluctant to report symptoms.

After surveying global trends, Prison Reform International concluded: [97]

> Solitary confinement remains a common practice in many [countries] despite overwhelming evidence of the harm it causes. Excessive use and degrading treatment or conditions for prisoners in detention remains commonplace in a large number of countries. Discriminatory application of solitary confinement continues to be a concern in many countries.[95]

The experiences in some other countries

We turn now to more in-depth descriptions of the use of solitary confinement in a few nations which have engaged in efforts to reform the practices. We rely in this section on published written descriptions of corrections systems in other countries. The RHOC did not visit any other countries or speak with official or advocates. Some members of the RHOC have international experience but their experiences are not reflected in this summary. Accordingly, while we can report data and describe policies, our knowledge of the conditions in general population is quite limited

England and Wales: One of the United Kingdom's responses to the pervasive conflict in Northern Ireland in the 1960s was to place Irish Republican Army prisoners held in England in solitary confinement.[98] But violence in the prisons did not lessen and by the 1980s, the British tried another approach. Rather than isolation, so called stable units of 10 individual cells with programming were established. In 1998 solitary confinement was reduced in favor of Close Supervision Centers (CSC). These programs were intended for the most dangerous prisoners who were given more control over their lives, rather than less. Prisoners in CSCs should have access to libraries, phone calls, mental health treatment, exercise, cooking facilities, and access to counsel to complain about the placement or the conditions. The CSC generated considerable favorable attention.

In January 2015, the total prison population in England and Wales was about 85,000 (140 prisoners per 100,000 population).[98] There were 1,586 segregation cells. The CSCs had a capacity of 54.

As Sharon Shalev points out, even if every segregation cell in England and Wales was filled with a prisoner who had been in segregation for 15 days or more, that would represent less than 2% of the total prisoner population.[99] Shalev cites to an Association of State Correctional Administrators (now called Correctional Leaders of America, CLA) report at the time the article was written estimating that 4.9% of prisoners in the U.S. are in segregation at a single point in time.[100] Shalev concludes that "long-term segregation is a far bigger part of the US prison system than it is in England and Wales." [99]

Moreover, most stays in segregation in England and Wales are brief: 71% of individuals in segregation spent fewer than 14 days there, 20% spent between 14 and 42 days, and 9% were segregated for longer than 84 days.[101] The average stay in CSCs, however, was 40 months in 2015.

Despite the favorable early attention paid to the CSC program and segregation reform generally, more recent reviews have been critical. The Prison Reform Trust criticized the CSCs and the segregation units in a lengthy and in-depth report in 2015. [115] In May 2021, the UN Special Rapporteur on torture criticized the CSCs in a report. He found the decision-making process is not transparent, the segregation period is not delimited, the procedure for reintegration back into the general prison population is not clear 'and the conditions of detention are comparable to solitary confinement. He said the use of CSC's runs contrary to the absolute prohibition of torture and other cruel, inhuman or degrading treatment or punishment, and risks amounting to arbitrary detention.[102] The Government disputed the findings.

Canada: After several court decisions finding many aspects of solitary confinement violated the nation's constitution, Parliament enacted a new law in 2019 replacing segregation with Structured Intervention Units (SIUs) in the nation's federal prison system.[103] The court decisions, from trial and appellate courts in British Columbia and Ontario held that prolonged or indeterminate isolation, using segregation in a discriminatory manner against Indigenous individuals, and segregating people with mental or other types of disabilities violated the Canadian Charter of Rights and Freedoms. One opinion held that for segregation to be constitutional, it had to be limited to 15 days.

The 2019 law provided that individuals placed in an SIU would receive four hours out of their cells and two hours of meaningful human contact per day. [103] However, a series of independent reports – the most recent one issued in May 2021 -- concluded that although there has been some progress in implementation of the law, by May 2021, measured against the Mandela Rules, 28% of SIU prisoners were in solitary confinement [104]. Moreover, since the law did not adopt the 15-day limit, many prisoners remain in SIU longer than 15 days. In other words, the investigators concluded that for many prisoners, SIUs are in fact solitary confinement under a different name.

The independent report says that that many prisoners in the SIUs did not receive the required four hours out of cell or their two hours of meaningful human contact. The report also concluded that hundreds of individuals were held in SIUs for over two months, that numerous people with previously diagnosed mental illnesses were placed in these units and that a

disproportionate number of those placed there were Indigenous. All these scenarios had been deemed unconstitutional by courts under the previous solitary confinement regime. [104]

In 2019, Canada's prisons held 38,570 persons (104/100,000).[105]

Sweden: Sweden's prison system that emerged in the 19th century was fashioned on the Philadelphia model which was based on the principle of housing all prisoners in solitary confinement. The strict disciplinary nature of penal policy continued for years after other nations had abandoned the concept of total solitary confinement.[106] Remnants of that system continue to plague the Swedish penal system.

In 2018, Sweden has a prison population of 6,391 (a rate of 63/100,000).[107]

Solitary confinement is not used today in Sweden as a disciplinary sanction. (Norway also prohibits solitary as a disciplinary sanction).[108] The only available disciplinary sanctions are postponing conditional release and a formal warning. (After serving two-thirds of their sentence, Swedish prisoners are conditionally released, perhaps under supervision.) However, prisoners may be isolated for other reasons – disturbing general order, being under influence of intoxicants, attempting to escape, and during investigations. Apparently, this is not considered discipline.

In addition, Swedish law allows judges to place restrictions on communication with the outside world on prisoners being held pending trial, called "remand prisoners."[109] These prisoners are commonly held in their cells 23 hours a day. Conditions in the cells were reported to be clean and well designed with sufficient natural light, but with few activities to pass the time. Remand practices have been criticized for years by the Council of Europe's Committee for the Prevention of Torture (CPT) as a violation of the European Human Rights Convention.[110]

Also, certain high security units may be a form of isolation. Nevertheless, one such unit with a capacity of 24 held 10 prisoners at the time of the CPT's visit was viewed favorably. [111] Prisoners could be placed in the unit if there was a high likelihood of an escape attempt or if the prisoner was likely to engage in criminal activity. Placement on the unit could be for the length of the person's sentence. The unit had a gym, prisoners had jobs, they were out of their cells 12 hours a day, and staff/prisoner relationships (for instance, prisoners and staff played board games and watched movies together) were viewed positively. Nevertheless, because the unit is so small there is limited communication among prisoners and the outside. Prisoners reported feeling very isolated.[112]

Spain: Solitary confinement is among possible disciplinary sanctions in Spain. Solitary may be imposed in a separate unit or in the prisoner's own cell. A doctor must visit each isolated prisoner daily and may suspend the sanction for health reasons. Pregnant women, women who have given birth within the past six months and nursing mothers may not be placed in solitary confinement. The sanction is limited to 14 days or fewer. It may only be imposed for "aggressive or violent attitude or when [the prisoner] repeatedly alters the daily life of the centre."[113]

Spain had 59,698 prisoners in 2018 (122/100,00). [114]

Denmark: A CPT report in 2019 found the material conditions in Danish prisons to be excellent.[115] However, the Committee expressed concerns about judicial restrictions on communications for remand prisoners, an issue similar to that in Sweden [109], though Denmark has made much more progress in remedying this problem [115]. The CPT noted, however, that isolation restrictions usually lasted no more than a few days or weeks. Denmark has a special security building that has a level of strict security. Prisoners in that unit have one hour of outside activity a day, another hour in the gym, and two hours with other prisoners outside their cells, including in the kitchen. However, there are no work opportunities.

The CPT also expressed concerns about the use of solitary confinement. Denmark has a limit of 28 days for solitary sanctions. [115] Of 4,752 sanctions in 2018, 674 were for more than 15 days. Placements in solitary increased during the few years prior to the report and the list of reason justifying the sanction had expanded. Use of solitary, albeit for short periods, appears to be a common practice in Denmark. Indeed, Manfred Nowak, a former Special Rapporteur on torture, has written that "In Denmark and Greenland, where I found by far the best prison conditions of all the countries that I visited, I nevertheless felt the need to express concern about the extensive use of solitary confinement."[116]

In 2018, Denmark held 4,227 prisoners (72/1000).[117]

South Africa: South Africa eliminated the use of the term solitary confinement in legislation in 1998 and 2008, replacing it with "segregation." [118] Segregation may never be used for discipline or punishment. However, a prisoner may be placed in a single cell for no more than seven days (a) upon the prisoner's request; (b) insofar as necessary to give effect to penalties restricting amenities (that is, recreation or other activities); (c) for medical reasons upon order of a physician; and (d) if the prisoner displays or is threatened with violence. The period of segregation may be longer than seven days in certain circumstances – up to 42 days for loss of amenities and up to two months for specific behavioral programming.

A medical staff person may order segregation to be discontinued if the prisoner's health is being harmed by the segregation.[118] There are no restrictions by gender or disability. Segregation orders are made by the facility head and must be reported and reviewed by the National Commissioner and the Inspecting Judge. Prisoners in segregation have daily access to outside exercise, reading materials, showers, and regular visits to the same degree as other prisoners.

The authors of the report from which this information is drawn conclude that despite the statutory reforms, "solitary confinement still occurs under the guise of segregation."[118]

In 2018 there were 164,129 persons in South Africa's prisons (248/100,000).[119]

Argentina: The Special Rapporteurship of the Inter-American Committee on the Rights of Persons Deprived of Liberty (IACRPDL) visited Argentina's prisons in 2016. Their report focused on several issues including overcrowding, poor conditions, and solitary confinement. Isolation units typically held 50 to 60 prisoners.[120] According to prison officials the units are used to "protect the

integrity" of inmates with "coexistence problems." The isolation cells measure approximately 2.5 x 3 meters and are shared by three or four inmates who are locked up for 22 hours a day and spend two or three hours a day in the yard. The Rapporteurship noted a dilapidated infrastructure and squalid conditions in those units, the unventilated sleeping quarters, lack of privacy when using toilets, and damaged and exposed electrical fittings. Prisoners alleged a deficiency and insufficiency of the food provided, negligent healthcare, a lack of water, and an absence of educational or recreational activities.

Argentina has 103,209 prisoners in 2018 (230/100,000).[121]

Lessons from other nations

Although most nations use some form of Restrictive Housing, like the United States, many other countries have recognized the harms that isolation can cause and are taking steps to limit or eliminate its use. Individual countries, regional associations like the European Union, and international bodies like the United Nations are enacting laws and rules intended to reform the use of isolation in prisons and jails. The efforts are sometimes not linear – that is, there are sometimes early successes, followed by some setbacks, followed by renewed efforts at reform. Although the global picture remains dispiriting, there appears to be a strong desire for reform and several good models for how to achieve it.

VII. Restrictive Housing Impact on Prison Order and Control

Proponents of the use of Restrictive Housing claim its use can improve prison safety. Some ways in which administrative segregation is thought to improve prison safety include incapacitation, deterrence, and normalizing the general population.[122] For example, some correctional staff that we heard from during site visits believed separating some incarcerated people is sometimes necessary for safety reasons. There are criminological theories that support that claim, and others that do not. According to deterrence theory, the harsh, unpleasant conditions of Restrictive Housing and the expectation that breaking the rules would result in placement there would deter behavior. There are also theories, for instance, social bond theory, labeling theory, as well as others, that claim the harsh conditions of Restrictive Housing would only increase criminal behavior through weakened social bonds, negative labels, and fewer rehabilitative opportunities.[123]

In researching the use of Restrictive Housing and its effects on prison safety it is evident that there is limited research on this topic. A major reason for the lack of research is that there is enough documented harm of solitary confinement that it would be unethical to subject anyone to the conditions for the purpose of research. Further, incarcerated people are identified as a vulnerable and protected class and are therefore subjected to greater protections than the general population. The limited number of empirical studies that exist rely on examining the practice as it occurs within correctional systems. They therefore often have methodological issues such as small numbers of outcomes examined, or not including comparison groups.[123] A publication which reviewed existing literature regarding segregation and prison misconduct, found only 16 of the

initial 26 studies found focused on the behavioral effects of segregation.[124] Many of the Restrictive Housing studies that do exist are focused on the mental health of individuals in Restrictive Housing rather than prison climate and safety.[123]

The argument that Restrictive Housing improves prison safety does not seem to be supported by existing research as the findings have been inconsistent and are lacking in number. Research into the effects of Restrictive Housing "are inconsistent: sometimes improving order,[125] sometimes making it worse,[126] [127] [128] [125] but mostly having no effect."[126] [129] [130] [127] [125] Multiple publications on institutional use of disciplinary segregation and its effects on misconduct and institutional violence, find that "disciplinary segregation does not have a significant effect on inmates' rates of misconduct or violence." [124] [129] [131] [128] [125] A multi-state study conducted in 2003 produced mixed results initially, finding supermax prisons did not reduce inmate on inmate violence, but found that these facilities may have increased staff safety.[126] Though some researchers state "the evidence does not support supermax prisons are responsible for reducing systemwide levels of violence," [127] others have found that the opening of a supermax facility has had a normalizing effect on prison systems, such as found in Illinois, which experienced 29 fewer lockdown days per month; a decline of 29% since the opening of the facility.[125]

The Urban Institute conducted a survey of 600 prison wardens on the use of Restrictive Housing for managing gang affiliates.[132] While the definition of Restrictive Housing in this survey may not be consistent with the CJRA, the finding are as follows: the survey showed that 83% agreed with the use of Restrictive Housing for managing gang affiliates and gang leaders, finding the use of Restrictive Housing and the removal of gang members was perceived by wardens to smooth tensions and control violent and non-violent behavior in general population. Arizona found a reduction in violence and Texas found a reduction in homicide and assaults. However, Texas also found gang leader segregation, or the transfer of gang leaders, had no effect; gang affiliated people leaving Restrictive Housing engaged in more misconduct than non-affiliates upon return to general population.[133] There have also been some studies that indicate using Restrictive Housing to manage gang members increases prison safety while others have had mixed results.[122]

While the safe operation of prison includes the ability to separate individuals who pose an unacceptable risk to safety and security, in many states, work is being done to limit the use of Restrictive Housing or improve the conditions within it. In a report by the U.S. Department of Justice (2016), several states reported either positive outcomes or no negative outcomes in prison safety after instituting changes to Restrictive Housing.[134] Some of the changes made at the facilities included increasing alternatives to Restrictive Housing, reducing Restrictive Housing population, creating segregation step-down programs, modifying sanction guidelines, eliminating indeterminate sentences in Restrictive Housing, and expanding cognitive behavior and skill-building programs.

The limited research and data on this topic also apply to the impact of Restrictive Housing on corrections officers and non-security staff working in Restrictive Housing settings. However, a 2021 examination of Correctional Officer Suicide and Wellbeing at the MA DOC found that correctional officers are more susceptible than the general population to negative mental health

consequences and increased risk for suicide.[135] There is also evidence that suicide among DOC correctional officers is more common at Souza Baranowski Correctional Center, and the now closed MCI-Cedar Junction facility. In speaking with groups of corrections officers at various DOC facilities we heard from officers that working in Restrictive Housing units can exacerbate some of these concerns.

In speaking with corrections officers, some reported that there are occasions whereby a person is placed in Restrictive Housing following a violent assault on a corrections officer, staff member or fellow incarcerated person. The result of this is that a cohort of individuals who may pose serious security risks are placed together in one unit, which often creates serious safety challenges for corrections officers assigned to these units. Corrections officers feel that working in specialized units, such as Restrictive Housing also impacts an officer's mental and physical health.

The RHOC was able to interview many correction officers, mental health and medical staff throughout the Commonwealth who work in general population and RH. From these interviews, the RHOC heard from some staff members that RH is vital to maintaining prison order and control. Specifically, some officers expressed concern about where incarcerated people who present serious security risks would be placed if RH were to no longer exist, particularly in situations where RH is used to separate individuals following a violent assault.

VIII. Conditions of Restrictive Housing in the Commonwealth

The CJRA also requires the RHOC to gather information regarding the use of Restrictive Housing in correctional institutions and requires that the DOC and counties provide the Committee with access to their facilities.[136] Accordingly, the RHOC toured many correctional facilities, as described in section IV that used Restrictive Housing units, with the generous cooperation of staff in all prisons and jails, as reflected in this report. As noted above, the Committee's tours and information gathering covered the period January 2019 through December 2021, and the discussion of Restrictive Housing conditions is limited to this period.

As noted, due to the various practices at the counties and the DOC it is difficult for the RHOC to summarize the use of Restrictive Housing across the Commonwealth. Between the fall of 2019 and summer of 2021, the RHOC visited seven of the DOC facilities with RH and visited 10 counties, of which some continued to report that they do not have Restrictive Housing based on their interpretation of the law as noted above. Most of the DOC visits were held prior to the COVID-19 pandemic. Due to the pandemic, the work of touring and visiting was delayed and once work in this area was able to resume it was done both in person, hybrid, and the RHOC was accommodated with virtual visits at three of the counties - Essex, Franklin, and Suffolk HOC. Virtual tours were not ideal, but allowed the RHOC work to continue.

There are no general themes this Committee could gather across the Commonwealth regarding the Conditions of RH. This is due again to the great diversity within the system between

the DOC and the counties, and amongst the counties themselves. This section will focus mainly on the observations of the conditions seen and reviewed at the DOC since they had the most consistency across its facilities.

DOC Practices

There was strong evidence that the requirements of CRJA were being met in the DOC's Restrictive Housing Units, as observed through policy, review of handbooks, and during site visits. However, conditions in the DDU were far harsher, and some observers argued that CJRA requirements regarding conditions, privileges and reviews were violated while others contend, they were not. It was observed that the DOC did transition two of the DDU wings to units that afforded additional out of cell time, beyond the definition of Restrictive Housing. One wing was now for those with SMI diagnosis serving a DDU sanction, and they were afforded at least 3 hours of out of cell time daily to include additional recreation, albeit in a restraint chair, and one weekly group with a mental health provider. The other wing was converted to a Limited Privilege Unit (LPU), which allowed the facility to close the "10 Block," which was historically used to house individuals posing an unacceptable risk in general population. The LPU did not meet the definition of RH due to the additional one hour out of cell offered daily, in a restraint chair, and was not utilized for DDU sanctions, rather for an alternative to non-disciplinary Restrictive Housing. Individuals held in these units described their conditions as extremely harsh.

Restrictive Housing Units

Some general observations of the conditions in Restrictive Housing in the Department of Correction include:

- Notifications and certifications were being provided as required.
- Periodic reviews were occurring as required.
- Tablets were available at most of the RHUs visited, and radios are provided.
- Programming with associated earned good time was available in these units but typically done through packet work by individuals alone in their cells.
- These units remained highly restrictive, with limited time out of cell daily; restraints employed during indoor recreation and outdoor recreation in individual cages; and meals alone in cell. However, members of the Committee disagreed as to whether these restrictions appeared to violate the statute.

Departmental Disciplinary Unit

The June 2023 closure of the DDU marked the end of long-term disciplinary Restrictive Housing in the DOC, in which people served sentences of up to ten years of highly regulated and

very restrictive incarceration per offense.[10] This was widely applauded, as long-term confinement of this nature is widely known to negatively affect mental health and wellbeing.

The following were conditions of confinement specific to the DDU as based on the DDU Inmate Orientation Manual[137] and the Committee's site visit:

1. Out of cell recreation (one hour, five days per week) in an individual outdoor cage, "unless security or safety conditions dictate otherwise."[138]
2. Food served through a slot in the door.[139]
3. No radio for the first 30 days of confinement, and then only if available.[140]
4. No television for the first 60 days, and then only if available.[141]
5. Visitation: no personal visits for the first 30 days; one visit during the second 30 days; two visits per month after 60 days, three visits per month after 90 days; and four visits per month after 120 days.[142]
6. Limited telephone calls: one on entry into the DDU; two calls during the first thirty days; three calls during the second 30 days; four calls per month after 60 days; five calls per month after 90 days; and six calls per month after 120 days.[143] These restrictions were a concern for individuals held in the DDU, as inmates noted they can go long periods of time without connecting to social supports.
7. Canteen was far more restrictive than in general population.[144]
8. Limited property, including no personal tablets.[145]
9. Limited showers (three times a week, for 15 minutes per shower).
10. DDU inmates who were accused of disciplinary violations could be placed on awaiting action status for up to 72 hours, during which they had no out of cell time and their property was removed.[146]
11. At the time of the RHOC site visit programming was offered through paper packets and limited in person groups by Spectrum Health Systems contract employees. There was earned good time available through both of these opportunities.
12. Persons in the DDU were given reviews required by the CJRA, but were not allowed to participate in person in these reviews, as were those in RHUs.

Some members of the RHOC maintain that some of these restrictions appear to have violated CJRA provisions requiring that prisoners in RH receive "the same access to canteen purchases and privileges to retain property in a prisoner's cell as prisoners in the general population at the same facility; provided, however, that such access and privileges may be diminished for the enforcement of discipline for a period not to exceed 15 days in a state correctional facility… for each offense or where inconsistent with the security of the unit" and "access to a radio or television if confinement exceeds 30 days."[147]

Specialized units in the DDU building

After the CJRA was enacted, the DOC created two units within the DDU building: the Serious Mental Illness Unit (SMI Unit), for those with SMI who would otherwise be in the DDU, and the Limited Privileges Unit (LPU), holding people in long-term, non-disciplinary Restrictive Housing.

The Falcon consultants considered both units to be Restrictive Housing, noting that they were "permeated by the punitive culture of the DDU more broadly." [5] As noted below, restrictions on visits and telephone calls added to the restrictive conditions in these units.

During visits to MCI Cedar Junction on 12/17 and 12/18/2019, the Committee observed the following conditions in both units:

- Those held in the units were offered out of cell time for three hours a day (1.5 hours restrained in restart chairs for programming or recreation, and 1.5 hours outside), though in the LPU the amount of LPU indoor recreation varied according to the individual's disciplinary record.
- Meals were eaten alone in cell
- Canteen access and property allowed in cell were highly restricted compared to the general population.
- Those in the SMI Unit were allowed only six phone calls a week, and those in the LPU only two.
- In the SMI Unit people could earn no more than to six visits a week, and in the LPU no more than two visits a week were allowed, even though the DOC visitation regulations (103 CMR 483.09) required three visiting periods per week.
- Because these units were not considered Restrictive Housing, the various reviews required by the CJRA were not done.

During the RHOC's site visits, particular concerns were raised regarding those with SMI held in the SMI unit. Staff indicated that everyone in the SMI unit was waiting for placement in one the Secure Treatment Units (STUs). The RHOC recognizes that there was a sustainable change in the definition of SMI through this legislation, and as such the number of those now identified as SMI grew once this definition was put into effect. Secure Treatment Units long predate CJRA with the Secure Treatment Program (STP) opening in 2008 and the Behavior Modification Unit (BMU) opening in 2010. Both programs were designed with a narrower, more traditional, definition of SMI and were thus designed to address more acute clinical needs, and as a clinical intervention for those in the highest need of treatment while in the most restrictive setting in the system, DDU. Both units offer more in-depth mental health and behavioral treatment than the SMI unit, due to the high level of clinical need they were developed for. Regardless of the change in the definition of SMI, it was observed that there were long backlogs for STU beds. Concerns were raised that the three hours a day out of cell in the SMI unit was problematic in therapeutic

terms.

County Practices

The Counties hold over half of the Commonwealth's incarcerated population (some 20 percent more than DOC), a substantial majority not yet convicted of a crime. Yet these 14 separately administered correctional systems receive far less public scrutiny and oversight than DOC. Conditions vary widely between counties. While county Sheriffs and administrators did their best to accommodate the RHOC for tours, nearly all were conducted hybrid or remotely due to the pandemic. Furthermore, information gathered from the counties was limited, due in part to their interpretation of the law and practices, as described in Section V.

Therefore, it is not possible to generalize about conditions in the counties, nor is it possible to provide comprehensive information on each county. While all counties maintained units with confinement of 21.5 to 23 hours per day (in the case of Hampden county), compliance with the CJRA's requirements varied greatly in terms of the minimal privileges, procedural reviews, and the diversion of populations such as those with SMI and those held for their own protection. There was also tremendous variation in disciplinary procedures, leading to long stays in Restrictive Housing awaiting a disciplinary hearing in some counties but not others. One problem observed across the counties was a lack of services for those with the most severe mental health and behavioral needs, who are particularly likely to be subject to discipline and to be held in Restrictive Housing. The RHOC is committed to oversight of the counties and will work to improve data collection and more systematically gather information during future site visits.

IX. Cost of Restrictive Housing in the Department of Correction

The Legislature, as part of the CJRA, also tasked the RHOC with examining how Restrictive Housing impacts incarceration cost.[2] The DOC, at the request of the RHOC, compiled relevant data and estimated the annual staffing cost of housing incarcerated individuals in any Restrictive Housing setting, based on the utilization and staffing patterns for Restrictive Housing on 1/1/2022, 2/1/2022, and 3/1/2022. These dates were from the last three months that the Department utilized Restrictive Housing, outside of the Department Disciplinary Unit, and were used as reference points to estimate the annual cost of Restrictive Housing. Using this information and comparing it to staff rosters during the same time, the DOC has provided an estimate of the annual staffing costs of Restrictive Housing as requested by the RHOC. The RHOC acknowledges that other costs exist, such as building maintenance/facilities upkeep, utilities, basic needs (nutrition, medical supplies, recreational materials). However, delineating or accessing data on these costs would have been extremely complex and time consuming, well beyond the capacities of this Committee.

The purpose of this exercise is to compare the estimated staffing costs associated with Restrictive Housing and that of non-Restrictive Housing. For the purposes of this analysis, non-Restrictive Housing is defined as any housing status outside of Restrictive Housing and is not

limited to general population. This analysis is limited to the following locations: Mass Treatment Center, MCI-Concord, MCI-Norfolk, MCI-Shirley, NCCI Gardner, OCCC, SBCC, and the DDU at MCI-Cedar Junction; these were the only locations in which Restrictive Housing was a possible placement during the referenced time frame. This is an estimated annual cost analysis based on the three-month data indicated above, and for only these locations. Multiple requests were made to the county HOCs to request similar data; however, none were provided.

As this is a limited look at the estimated staffing costs related to the utilization of Restrictive Housing and non-Restrictive Housing at the above-mentioned facilities, to best ensure accurate results, we focus on the functions of security, mental health, medical, and programming staff. These staffing types were utilized because each staffing type performs different functions relative to the population.

A. Restrictive and Non-Restrictive Housing Population

The estimated annual staffing costs for this analysis are based on the average DOC incarcerated population for the three-month period between January and March 2022.[148] [149] The population is broken into those who were in Restrictive Housing and those who were not (non-Restrictive Housing) within the time period. The total number of incarcerated persons housed in facilities that had Restrictive Housing was estimated at 5111, and as seen in **Figure 1** below, 3% were in Restrictive Housing and 97% were in non-Restrictive Housing units.

Figure 1. Percentage of Incarcerated Persons by Housing Type

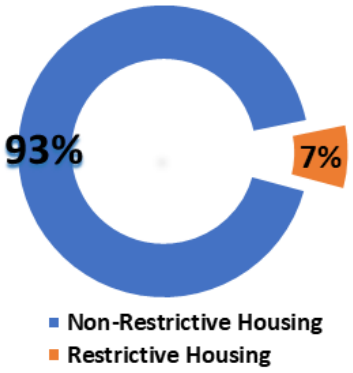
B. Estimated Staffing Allocation

Included in this estimate are only facilities which had a housing unit with a Restrictive Housing type during this time and is further limited to the associated staffing allocation. **Table 1** delineates the estimated annual percentage of the security staff, mental health and medical staff, and program staff who work in Restrictive Housing as compared to those not assigned to Restrictive Housing.

Table 1. Percentage Estimates of Staffing Allocation

Assignment	SECURITY STAFF	MENTAL HEALTH & MEDICAL STAFF	PROGRAM STAFF
Restrictive Housing	8%	5%	9%
Non-Restrictive Housing	92%	95%	91%

Figure 2 is a breakdown, by percentage, of the estimated allocation of security, mental health and medical, and programming staff assigned to a facility that had Restrictive Housing. This demonstrates that at these facilities 93% of staff are assigned to functions outside of Restrictive Housing (non-Restrictive Housing) and 7% to Restrictive Housing. Thus, although 3% of people in custody were in Restrictive Housing, that housing was allocated 7% of staff resources, over twice the rate of general population.



C. **Estimated Annual Staffing Cost Per Incarcerated Person**

This section details the estimated annual staffing costs per incarcerated person to compare the relative cost by individual person in Restrictive Housing, as compared to non-Restrictive Housing. Overall, it is estimated that the annual cost per incarcerated person in Restrictive Housing is approximately three times as much compared to the cost of an incarcerated person in non-Restrictive Housing.

Table 2 illustrates the cost specific to security staff for each person in Restrictive Housing, with an estimated cost of $149,567 for security staffing per incarcerated person, and an estimated cost of $46,775 for security staffing per person in non-Restrictive Housing, annually.

Table 2. Estimated Annual Cost per Incarcerated person - Security Staff

HOUSING TYPE	SECURITY STAFF
Restrictive Housing	$149,566.62
Non-Restrictive Housing	$46,774.68

Table 3 illustrates that for each person in Restrictive Housing, it costs an estimated $15,646 for mental health & medical staffing annually, whereas, for each person in non-Restrictive Housing, it costs an estimated $8,627 for mental health & medical staffing annually.

Table 3. Estimated Annual Cost per Incarcerated person Treatment Staff

HOUSING TYPE	MENTAL HEALTH & MEDICAL STAFF
Restrictive Housing	$15,645.73
Non-Restrictive Housing	$8,626.50

Table 4 illustrates that for each person in Restrictive Housing, it costs an estimated $5,421 for program staffing annually, whereas, for each person in non-Restrictive Housing, it costs an estimated $1,405 for programming staff annually.

Table 4. Estimated Annual Cost per Incarcerated person Program Staff

HOUSING TYPE	PROGRAM STAFF
Restrictive Housing	$ 5,421.22
Non-Restrictive Housing	$ 1,404.53

X. Committee Recommendations

The CJRA requires the RHOC to issue "a report offering its recommendations on the use of Restrictive Housing in the Commonwealth, including ways to minimize its use and improve outcomes for prisoners and facility safety." G.L. c. 127, §39G (d). Restrictive Housing is defined by the CJRA, as "a housing placement where a prisoner is confined to a cell for more than 22 hours per day." This is similar to the definitions provided by the American Correctional Association (ACA).[2] The CJRA guarantees to those in Restrictive Housing minimum conditions and privileges. G.L. c., 127, §39 (b). It also forbids the use of Restrictive Housing for people with serious mental illness and those held only for their own protection unless administrators certify that there is no alternative, see G.L. c., 127, §§39A (a) and (b), and in all cases forbids the use of Restrictive Housing based on LGBTQI status and for pregnant women. See G.L. c., 127, §§39A (c) and (d). Additionally, it requires periodic reviews to ensure that Restrictive Housing holds only those who pose "an unacceptable risk to the safety of others, of damage or destruction of property, or to the operation of a correctional facility." G.L. c.127, § 39B.

With the 2023 closure of the Departmental Disciplinary Unit, the DOC no longer has designated Restrictive Housing, as legally defined, since by policy it allows at least three hours out of cell in all units. Many county sheriff's departments recognize no obligation to comply with the Restrictive Housing requirements in the CJRA, taking the position that 22-hour confinement does not constitute Restrictive Housing under the law, or because their facilities confine people for no more than 22 hours daily. Regardless of whether Restrictive Housing was acknowledged or not, many counties did not provide individuals in non-disciplinary restrictive confinement with the canteen, property, and other privileges required by G.L. c. 127, § 39 (b), treating them the same as those held under disciplinary sanction. Compliance was also uneven with regard to provisions excluding from Restrictive Housing people with serious mental illness and those held only for their own protection, G.L. c. 127, § 39A (a) and (b). In some instances, county personnel were not familiar with the CJRA's definition of serious mental illness, employing a far narrower definition.

The recommendations below address existing Restrictive Housing practices and measures taken to reduce its use and improve outcomes, including the diversion and treatment of people with "serious mental illness," as legally defined at G.L. c. 127, § 1. Additionally, to promote sustainability of these movements away from Restrictive Housing as defined by the CJRA, and to promote best practices across the Commonwealth, it would be ideal for the RHOC to have a better understanding of the new units used by the DOC and Sheriff's Offices. Looking toward effective oversight in the future, these recommendations also suggest changes to the CJRA's reporting requirements, expanding its authority for oversight outside of the statutory definition of RH, and changes to the statutory provisions governing the RHOC.

I. <u>The Legislative Mandate of the RHOC</u>

[2]"Standards for Adult Correctional Institutions (ACI) Fifth Edition / Fourth Edition" American Correctional Association in cooperation with the Commission on Accreditation for Corrections 5th Edition: March 2020 (Updated Jan 2021) "Inmates who pose a direct and clear threat to the safety of persons or a clear threat to the safe and secure operation of the <u>facility</u> are separated from <u>general</u> population and placed in <u>restrictive housing</u> units / cells for periods of time 22 hours per day or greater.

The following measures will enable the RHOC to effectively oversee the evolving landscape of Restrictive Housing. Therefore, we recommend that the legislature consider codifying the following changes to G.L. c. 127, §39G (d).

Recommendations:

1. **Clarify the definition of Restrictive Housing.** Currently Restrictive Housing is defined as "a housing placement where a prisoner is confined to a cell for more than 22 hours per day." Several counties have interpreted this to mean that 22-hour confinement is not Restrictive Housing and units permitting two hours out of cell are not subject to the CJRA reporting requirements or RHOC oversight. The definition should be amended to include housing placements where a prisoner is confined to a cell for "22 hours or more per day."

2. **Reporting Changes.** The CJRA imposes different requirements on the DOC and the counties relating to frequency and information reported. We suggest this be amended to ensure that the reporting is uniform for the counties and the DOC so that proper oversight, and comparisons can be made. The preference of the RHOC is the more detailed reporting requirements in statute for the DOC at a quarterly and bi-annual rate be extended to the counties.

3. **Expand formal membership to include at least two formerly incarcerated individuals.** Individuals with lived experience in incarceration and Restrictive Housing have participated as informal members of the RHOC, with the assent of the full Committee, but have not had an official voice and vote on the Committee. This perspective is invaluable, alongside the perspective of representatives of the DOC and Massachusetts Sheriffs' Association. The legislature should consider formally adding at least two formerly incarcerated people to the RHOC.

4. **Expand formal membership to include at least one correction officer who works in a housing unit that is not considered general population by the agency and is used to separate those who pose a risk to the safety of the facility**.

5. **Require clinical licensing of the NASW member of the Committee and expand membership to include a person licensed in addiction medicine.** While there are seats on the Committee designated for the National Association of Social Workers (NASW), the Department of Mental Health (DMH), and the Massachusetts Association for Mental Health (MAMH), there are no specifications regarding the type of professional appointed by these organizations. The current NASW and DMH appointees do hold clinical licenses, but there is no requirement that this continues to be the case in the event of a new appointee. There is also no member licensed in addiction medicine. Clinical expertise in mental health and substance use disorders will ensure that the Committee can effectively evaluate the effects of Restrictive Housing on people with these disorders and compliance with

components of the statute which pertain to the provision of mental health services and SUD treatment**.**

Therefore, the legislature should consider requiring that the RHOC member designated by the NASW have a clinical license (Licensed Independent Clinical Social Worker LICSW) and should consider adding a member licensed in addiction medicine, to be appointed by the Massachusetts Society of Addiction Medicine.

6. **Provide funding for the procurement and implementation of a data performance and analytics platform for the DOC and Sheriffs for external and internal facing dashboards.** The ability to generate real time data supports transparency and accountability; mechanisms to assess effectiveness of policy and practice, track outcomes, generate greater understanding of the Restrictive Housing landscape in Massachusetts, identify disparities and measure fiscal impacts and outcomes. Funding is necessary to ensure that dashboards can be used by all agencies in the manner to accomplish this goal.

7. **Provide the RHOC resources to comply with its mandate.** The RHOC currently has no financial resources to engage in its mission. EOPSS staff have performed tremendous and skillful service in organizing site visits, supporting the work of the Committee, and producing the report alongside their other full-time responsibilities. However, staff dedicated solely to the RHOC would enhance the Committee's capacity for data analysis, its ability to gather and review documents from various jurisdictions, its ability to document and share information gathered in site visits, to draft timely reports, and other core capabilities that are vital to effective oversight. The lack of financial resources also limits membership to people who can afford to engage in the work on an uncompensated basis or are able to do the work as part of their job, which compromises the Committee's ability to be inclusive of all perspectives and fully neutral.

   Therefore, we recommend that funding be appropriated to enable the RHOC to hire one or more staff people to administer the work of the Committee and to offer some compensation to members otherwise unable to provide service.

8. Create mechanisms to compel compliance. The RHOC believes that it has a responsibility to provide recommendations to the DOC and Sheriff's Departments regarding compliance with the statute and best practices. However, the RHOC has no ability to compel any action by these entities – even to demand timely compliance with the reporting requirements of section 39D. To obtain full compliance additional mechanisms are likely required. Therefore, we recommend*:

   a. The legislature should provide that failure to provide information required by the statute or the failure to cooperate with the RHOC in other ways required by law shall be referred to the Office of the Attorney General for enforcement review.

b. The legislature should devise a mechanism to ensure cooperation with the Committee if the Committee reports non-compliance by anybody that is required to do so under the law.

*The following members opposed these two recommendations: Andrew Peck, Kyle Pelletier, Hollie Mathews, and Sheriff Bowler.

9. **Expand the scope of the RHOC's mandate.** In order to assess the impact of the CJRA and oversee evolving practices, the legislature should expand the RHOC's mandate outside of the widely accepted definition of Restrictive Housing to include all units separated from the general population that house people deemed to pose an unacceptable risk in the general population, regardless of whether they are confined 22 hours a day or longer, or the overall purpose of these units. For a period of three (3) years following conversion from those conditions of confinement, the RHOC should continue to have jurisdiction and oversight authority to assess operational changes and study impact in order to make informed recommendations.*

*Sheriff Bowler opposed this recommendation and Andrew Peck abstained.

II. Diversion and Treatment of People with Serious Mental Illness

1. **Department of Correction's STP and BMU**

The Secure Treatment Program (STP) and Behavior Management Unit (BMU), operated by the DOC, were designed as clinical alternatives to and diversion from the DDU for individuals with serious mental illness, many of whom demonstrated extreme risk for violence. With the closure of the DDU, the Committee wishes to recognize that the meaningful therapeutic aspects of these programs should be maintained, but that aspects of the programs that may have been developed due to their original purpose be reviewed and redefined to ensure they align with the clinical purpose.

Recommendation: The DOC should continue to offer the STP and BMU as clinical placement options for individuals identified as needing a secure therapeutic setting that provides individual and environmental safety.

2. **Mental Health Watch:**

RHOC members visited "mental health watch" units at several facilities and discussed mental health watch processes with clinical staff at most facilities. Inasmuch as mental health watch is expressly excluded from the definition of Restrictive Housing in the CJRA, we did not undertake a close investigation of mental health watch processes. Nevertheless,

we are cognizant of the December 2023 agreement between the Department of Justice and the DOC. (Mental health watch is called Therapeutic Supervision in DOC facilities.) No similar agreement covers county correctional facilities, where we observed that practices vary widely. Ensuring humane treatment in a safe, therapeutic setting will encourage those at risk of suicide or self-harm to seek help.

Recommendation: County correctional facilities should use the December 2023 agreement between the DOJ and the DOC as a guide for assessing and, where necessary, reforming their use of mental health watch.

3. **Mental Health and Substance Use Services**
   Higher rates of quality comprehensive mental health and substance use services are associated with lower rates of arrest at the population level. Using this same logic within a prison setting could indicate that, addressing and preventing mental health/substance use disorders is a key mechanism of reducing and eliminating the use of Restrictive Housing. To effectively do this, the DOC and HOCs are tasked with 1) preventing the development/exacerbation of these disorders, and 2) addressing the symptoms of these disorders through evidence-based service delivery.

   a. ***Climate of prevention***: Prisons and jails are inherently stressful and traumatic environments. Massachusetts prisons and jails are no exception. However, during site visits the RHOC did observe a range of climates. Some facilities took greater strides towards prioritizing shared values across security and clinical staff to promote a mission of safety and wellness. In these facilities incarcerated people reported less stress (a key protective factor for better mental health) and greater access to mental health services. Some facilities also had greater ease of communicating with outside supports (i.e. enhanced visit/phone/mail policies), better access to the outdoors/recreation/activities to promote wellness, and safer housing conditions. All these factors help to mitigate the effects and prevent exacerbation or development of mental health/substance use disorders.

      Recommendation: All corrections agencies should promote a culture of prevention through building a shared mission between clinical and security staff to foster better access to mental health services and promote an environment of prevention through policies which promote wellness.

   b. ***DOC Mental Health and Substance Use Services***: The MA DOC's policies for mental health services (103 DOC 650 Mental Health Services) are publicly available. This document defines the credentials required to provide mental health services, the continuum of available services, and other key terms relevant to the intersection of Restrictive Housing and mental health, including the terms "Restrictive Housing" and "serious mental illness." In addition, it includes several pages detailing how mental health services should be provided to people who are placed in or diverted from Restrictive Housing. This policy also defines and

describes some key areas of substance use services, but several areas of available substance use programming (for example Correctional Recovery Academies), are described in another policy. During site visits the RHOC observed the implementation of this policy, particularly as it intersects with Restrictive Housing policy (103 CMR 423 Restrictive Housing) and received feedback on its perceived effects from health services/correctional staff, and incarcerated patients.

The DOC has a centralized Health Services Unit run by state employees and each prison has a designated mental health team employed by a private contractor. The onsite clinical teams are primarily comprised of licensed or license-eligible clinicians who hold master's degrees. They also assigned staff to cover the DDU and RHUs (during their existence) to facilitate continuity of care and relationship building between clinical and security staff. Quality of and access to services appears to vary by DOC facility, as noted by some of the incarcerated people interviewed. This may be based on the level of coordination among staff, staffing levels and demand in the prison population for mental health services. On the surface it appears that in facilities where relationships between clinical and security staff were strong and collaborative, with security staff reporting a commitment to facilitating mental health services access, incarcerated people reported a higher level of satisfaction than observed in other facilities where relationships between clinical and security staff were strained.

The Department distinguishes between Substance Use Treatment Services and Substance Use Treatment Programs in the 103 DOC 445 Substance Use Services policy, which is separate from the Mental Health Services policy referenced above. Treatment services are overseen by the Health Services Division and are provided by licensed professionals, whereas treatment programs are overseen by the Department's Program Services and focus on recidivism reduction programming, and do not appear to have the same licensing requirements.

The 103 DOC 650 Mental Health Services policy closely details substance use services for populations held under section 35 of chapter 123 of the General Laws, but for the much larger population of people held within the DOC, this is done in a separate policy as noted. As understood by the Committee, based on presentations to the RHOC and site visits, the DOC has multiple vendors providing various levels of substance use services. Medication assisted treatment and the required services such as counseling or groups associated with that level of care, are distinct from other forms of substance use programs also available. This care is provided by licensed professionals and follows DPH regulations. In contrast, staff providing substance use programs operate outside the purview of the Health Services Division and are primarily provided by unlicensed staff with bachelor's degrees. These services are focused on recidivism reduction addressing the criminogenic risk factor of substance use. These programs offer earned good time opportunities for engagement, and do not include a clinical treatment plan as they are not viewed as clinical interventions. The Department describes these as substance use programs rather than treatment. These services are available to people in the general

population. The residential substance use program (Correctional Recovery Academy) is only available in some facilities, while nonresidential group-based substance use programs are offered at a larger number of facilities throughout the system.

The separation of substance use services/programs from Health Services, and the use of non-clinical staff should be explored to determine if it runs counter to best practices in the community. Further, the historical restriction of people with disciplinary action from receiving services is counterproductive given that people with active symptoms of substance use (i.e., people with the highest level of need for services) are more likely to have disciplinary action for those symptoms. The recent elimination of Restrictive Housing and the move towards assessment units is a positive step towards improving access to existing services, but it does not address the questions we have on the quality of those services, services stemming from use of unlicensed staff and unintegrated services. This new process has not been fully explored or studied by this committee.

Recommendation:

i. The DOC should combine their separate policies on mental health care and substance use treatment services into one policy for all behavioral health care to align with best practice standards which support integrated care.
ii. The full continuum of substance use treatment services should be available to all incarcerated people to address the immediate and long-term substance use needs of those in their custody. In doing so, agencies should ensure treatment can be accessed even when disciplinary sanctions are imposed due to active substance use.
iii. Substance use treatment services should be delivered only by legally qualified staff. The Massachusetts Bureau of Substance Abuse Services outlines these standards.

c. **County Correctional Facilities**: County facilities do not have comparable details in publicly available policies to the DOC. During site visits and in presentations to the Committee, variations in mental health and substance use services were even greater among the facilities run by county Sheriff's departments. There were a couple of outliers who provided systems of care similar to the DOC; however, most had services which were quite poor. There were counties that did not have licensed staff at all, and others that had no access to confidential services. Counties also rarely designated staff to monitor their RHUs. Staffing ratios within the counties generally had more clients per clinician (larger caseloads) than the DOC, which is extremely problematic, as people incarcerated in jails often have much more acute behavioral health needs. Across county correctional facilities, staffing models vary. Some counties employed behavioral health staff as county employees, while others used contractor models like the DOC (some combining substance use services with mental health and others separating them). In those counties where staff were

employed by the county turnover appeared much lower which is generally positive; however, some of those counties also employed unlicensed staff which is problematic as their training/experience may not meet quality standards.

Most Houses of Correction did not have any inpatient or specialty services for mental health/substance use services. The Emergency Stabilization Units in Middlesex and Hampden Counties (each of which are supported by legislatively created budget line items) were positive outliers, but only provide short term crisis management. Like the DOC's STUs (which operated during the time of our site visits) they also have extremely restrictive conditions. The Dartmouth Behavioral Unit in Bristol County is also highly restrictive and designed only for those who would otherwise be in Restrictive Housing. Apart from these units, and referrals for evaluation to Bridgewater State Hospital (BSH), there is no inpatient mental health care. This lack of adequate mental health care causes many individuals with serious mental illness to cycle repeatedly between Restrictive Housing and general population, in many cases also cycling through mental health watch and evaluations in BSH.*

*The following members abstained from voting on the introductory language citing a lack of understanding as to what services county facilities do and do not provide: Andrew Peck, Kevin Flanagan, Kyle Pelletier, and Hollie Mathews.

Recommendation: All Sheriff's Departments should develop and adopt a single publicly available behavioral health policy which covers both mental health and substance use treatment services delivery, particularly in the context of Restrictive Housing. Such policies should also ensure that all facilities apply the basic same standards of quality care including providing, legally qualified mental health/substance use services providers, confidential treatment settings, appropriate staffing ratios, and access to a full continuum of integrated mental health/substance use services.

III. Extending protections in other forms of segregated confinement

Since the passage of the CJRA, the DOC and many county administrators have adopted policies prohibiting 22-hour confinement. In many facilities, units holding people thought to pose an unacceptable risk in general population remain more restrictive than general population units. Differences may include more limited out of cell time and the use of physical restraints while outside of one's cell. Acknowledging the transformative value and purpose of the CJRA reforms as well as the statutory purpose of this body, the following recommendations seek to apply the protections of the CJRA to people in those units.

Recommendations*:

1. Conditions of confinement should be individualized to maximize access to rehabilitative services including recreation, programming, telephone access, canteen access, access to visitation, and access to earned good time. Any restriction in access to these services should only occur through formal disciplinary sanctions which consider individual circumstances.

2. Any use of physical restraints such as handcuffs, shackles, "restart chairs," and "therapeutic modules" during recreation or programs must not be imposed unless there is an individualized determination based on accepted risk management principles that such a limitation is necessary. If such restraints are used for any amount of time for more than three consecutive days, there must be due process protections including a right to a hearing with legal representation, if the individual can secure such representation.

3. The minimum conditions and privileges required by the CJRA for persons in Restrictive Housing, G.L. c. 127 §§ 39-39H, should apply in the units designed as alternatives to restrictive housing in the DOC and in all counties.

*The following members abstained from voting on these three recommendations citing pending litigation and the fact that the Committee has yet to study non-Restrictive Housing units: Andrew Peck, Joanne Barros, Hollie Matthews, and Kyle Pelletier.

XI. Conclusion

The Committee has performed an in-depth review of Restrictive Housing in the Commonwealth over the past several years and done its best to critically examine the use of Restrictive Housing at both the state and county levels amid significant changes to the Restrictive Housing system, particularly in the DOC. The changing landscape presented the Committee with significant challenges and required it, on multiple occasions, to pivot and modify its approach to studying Restrictive Housing and producing this report. It's the Committee's hope that this report will provide a solid baseline about the history of Restrictive Housing, its use in the Commonwealth, and some of the problems and challenges associated with the use of Restrictive Housing, with recommendations to consider for improving the system for all of those involved.

XII. References

[1] *An Act Relative to Criminal Justice Reform*, Chapter 69 of the Acts of 2018. (CJRA)
[2] This requirement appears at M.G.L. c. 127, §39G(b)
[3] M.G.L. c., 127, §§ 39, 39A, 39B
[4] Department of Corrections. *HOC Monthly Restrictive Housing Counts*. (2019-2022) https://www.mass.gov/lists/hoc-monthly-restrictive-housing-counts
[5] Falcon, Inc. (2021) *Elevating the System: Exploring Alternatives to Restrictive Housing*. (2021) "Falcon Group Report" or "Falcon Report". https://www.mass.gov/doc/falcon-report/download
[6] *Open Meeting Law*, M.G.L. c. 30A, §§ 18-25
[7] Link to RHOC minutes and notices on mass.gov: https://www.mass.gov/lists/restrictive-housing-oversight-committee-meeting-documents
[8] The CJRA defines Restrictive Housing as confinement of "more than 22 hours per day." G.L c. 127, § 1. The DOC and some counties therefore reported as Restrictive Housing all confinement of 22 hours per day. However, a number of countries maintain that they do not have Restrictive Housing because they provide out of cell time of "at least 2 hours a day, or "a minimum of 2 hours a day," or that persons in their custody are "not confined more than 22 hours" per day. As detailed in Section 2, many initially reported 22-hour confinement as Restrictive Housing, but at some point stopped.
[9] Department of Corrections. (June 29, 2021) *DOC Announces Initial Steps Toward Elimination of Restrictive Housing.* EOPSS. https://www.mass.gov/news/doc-announces-initial-steps-toward-elimination-of-restrictive-housing
[10] Department of Corrections. (June 21, 2023) *Department of Corrections Ends MCI-Cedar Junction Housing Operations and Dissolves Department Disciplinary Unit*. EOPSS. https://www.mass.gov/news/department-of-correction-ends-mci-cedar-junction-housing-operations-and-dissolves-department-disciplinary-unit
[11] Department of Corrections, *Restrictive Housing Monthly Reports*, (2019-2022). https://www.mass.gov/lists/doc-monthly-restrictive-housing-counts
[12] 103 CMR 430 : *Inmate Discipline.* (2019). https://www.mass.gov/regulations/103-CMR-43000-inmate-discipline
[13] Department of Corrections, *Restrictive Housing Quarterly Reports*, (2019-2022). https://www.mass.gov/lists/quarterly-restrictive-housing-report
[14] The race/ethnicity makeup of individuals receiving DDU sanctions was calculated by aggregating the individualized data describing DDU sanctions during the first quarter 2019 – 2021 reported in the DOC Quarterly Restrictive Housing Reports. The fourth quarter 2021 Quarterly Restrictive Housing Report was used to compare to January 1, 2022 snapshot data, as the RH analysis within this report goes through the end of 2021.
[15] Sullivan, S., Digard, L., & Vanko, E. (2018, May). *Rethinking Restrictive Housing - Lessons from Five U.S. Jail and Prison Systems*. (Vera Institute of Justice) Retrieved from Vera Institute of Justice: https://www.vera.org/publications/rethinking-restrictive-housing
[16] Beck, A. J. (2015). Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12. Office of Justice Programs, Bureau of Justice Statistics. U.S. Department of Justice. Retrieved from https://bjs.ojp.gov/content/pub/pdf/urhuspj1112.pdf
[17] Henry, Brandy F. (2022) Disparities in use of disciplinary solitary confinement by mental health diagnosis, race, sexual orientation and sex: Results from a national survey in the United States of America. Crim Behav Ment Health. 2022 Apr;32(2):114-123. doi: 10.1002/cbm.2240. Epub 2022 Apr 3. PMID: 35373416; PMCID: PMC9373232.
[18] Massachusetts Department of Corrections, (2018). *The Influence of Brain Development Research on the Response to Young Adult Males*. https://www.mass.gov/lists/briefs-and-evaluations , p. 3.
[19] Winters, K.C. (2008). Adolescent brain development and drug abuse. The Mentor Foundation. Retrieved from https://langley.bigbrothersbigsisters.ca/wp-content/uploads/sites/145/2017/11/Adolescent_Brain_Bochure.pdf
[20] *Roper v. Simmons*, 543 U.S. 551 (2005). See also *Diatchenko v. District Attorney for the Suffolk District*, 466 Mass. 655 (2014); *Commonwealth v. Mattis*,493 Mass. 216 (2024); *Miller v. Alabama*, 132 S.Ct. 2455 (2012)*; Graham v. Florida*, 560 U.S. 48 (2010).
[21] James, K. & Vanko, E. (April, 2021). The Impacts of Solitary Confinement. The Vera Institute of Justice

[22] Dimon, Laura. (June 30, 2014) How Solitary Confinement Hurts the Teenage Brain. The Atlantic
[23] Id.
[24] Steinberg, L. (2017). Adolescent brain science and juvenile justice policymaking. Psychology, Public Policy, and Law, 23(4), 410-420. http://dx.doi.org/10.1037/law0000128
[25] Williams, Brie A. (2016) *Older Prisoners and the Physical Health Effects of Solitary Confinement*, Vol. 106, Am J Public Health. 2126, 2127 (2016). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5105008/.
[26] G.L. c. 127, § 39A(b)
[27] G.L. c. 127, §§ 39B
[28] G.L. c. 127, § 39A(a)
[29] G.L. c. 127, § 1
[30] G.L. c. 127, §39D(b)(v)
[31] See 103 CMR 423.09 (3)
[32] The Department of Corrections, EOPSS, and the RHOC have agreed to continue reporting and publishing data beyond 2021, but as mentioned in the introduction, this report's analysis is limited to 2019-2021.
[33] Barnstable County administrators explained during the RHOC tour that their Administrative Segregation Unit, G Pod, which allows two hours out of cell daily, is not considered Restrictive Housing, but the Disciplinary Detention unit, F Pod is considered RH because it allowed only one hour out of cell daily. Barnstable's Restrictive Housing reports accordingly do not include G pod, and the resulting reporting of F pod alone is misleading as an indicator confinement of 22 hours or more daily.
[34] Hampshire and Worcester counties stopped reporting their 22-hour confinement in the first quarter of 2020, and Norfolk in the fourth quarter of that year. During the RHOC site visit to Norfolk County on March 29, 2022, administrators indicated that the policy is to allow at least 2 hours and fifteen minutes per day out of cell. However, for the months that Norfolk has not reported, it is counted as "not reporting" rather than as having zero Restrictive Housing . This is because all six people interviewed were adamant that they were allowed out no more than two hours a day. It should be noted that the recently-appointed Superintendent expressed a commitment to allowing at least 2.5 hours out of cell by September 2022 and 3 hours by 2023.
[35] Massachusetts Sheriffs Association. (December, 2022). *Annual Restrictive Housing Report for 2021.* https://www.mass.gov/doc/2021-msa-restrictive-housing-annual-reporting/download.
[36] G.L. c. 127, §39D(b)(iii)
[37] Correctional Leaders Association and Arthur Liman Center for Public Interest Law at Yale Law School. (2022, August). Time in Cell: A 2021 Snapshot of Restrictive Housing. Retrieved from https://law.yale.edu/sites/default/files/area/center/liman/document/time_in_cell_2021.pdf
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[42] Colorado House of Representatives. (Signed 6/24/2021, effective 1/1/2022) HB21-1211 : Regulation of Restrictive Housing in Jails. https://leg.colorado.gov/bills/hb21-1211
[43] United Nations General Assembly. (2016). United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Seventieth Session, Agenda Item 106. Retrieved from https://documents.un.org/doc/undoc/gen/n15/443/41/pdf/n1544341.pdf
[44] N.J. Stat. §§ 30:4-82.5-82.11, 2019
[45] A further note on New Jersey's terminology is warranted and illustrates some of the difficulties comparing one state to another. In New Jersey, what we call Restrictive Housing in our state law is called "isolated confinement"

in the New Jersey statute. See New Jersey Isolated Confinement Restriction Act, S. 2588, 216th Leg., Reg. Sess. (N.J. 2014). We have learned that beginning in 2016, the New Jersey Department of Corrections (NJDOC) did not acknowledge the term "isolated confinement" and instead used "close custody," "Restrictive Housing," "restricted housing," "Administrative Segregation," "Pre-Hearing Disciplinary," "Management Control," "Protective Custody," "Voluntary Protective Custody," "Involuntary Protective Custody," and "Temporary Close Custody" to describe then-current forms of isolated confinement. Also, "Gang Unit" and "Capital Sentencing Unit" were used to describe units that had been eliminated starting in 2010. Former terms are documented at N.J.A.C. 10A:5-1.1: "Capital Sentence Unit" deleted and "Temporary Custody" replaced by "temporary close custody" in 2008; "Security Threat Group Management Unit" deleted in 2011; and "Segregation Unit" replaced by "Close Supervision Unit" in 2014 (N.J. Admin. Code § 10A:5-1.1, 2021). Other terms used have been "restricted room engagement," "disciplinary segregation," and "special needs units."
In 2020, the NJDOC proposed to include in N.J.A.C. 10A:5-1.1(a)4 current names for solitary confinement units ("close custody units") including Pre-Hearing Disciplinary Housing (P.H.D.H.), Management Control Unit (M.C.U.), Restorative Housing Unit (R.H.U.), Adjustment Unit (A.U.), Protective Custody Unit (P.C.U.), and Temporary Administrative Housing Unit. New Jersey Department of Corrections Office of the Commissioner Administrative Rules Unit [ARU], 2020a, p. 2. These terms can be confusing, but we believe our reporting is accurate.

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