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## Older Prisoners and the Physical Health Effects of Solitary Confinement

In February 2016, on his 69th birthday, Albert Woodfox was freed from prison after he had spent more than 40 years in solitary confinement.

I met Mr. Woodfox in 2006 when I served as his legal case's medical expert. He was the last incarcerated member of the "Angola 3," three black prisoners confined to solitary for decades. In 1972, he was convicted for the killing of a white prison guard, a crime for which he steadfastly claims innocence. His release followed two overturned convictions (one for inadequate representation, one for racial discrimination).

When I toured the isolation unit, men languished listlessly on their cell's concrete floor. Metal fans clanged loudly, circulating hot air, while men tried to communicate by yelling and banging out messages against their cell fronts' steel bars.

While waiting to meet Mr. Woodfox, I was more nervous than I had been since medical school, maybe ever. How should I talk with someone who had been isolated for decades? What should I ask as one of few people he would be close to in years, as one of even fewer who would touch him not to shackle him but to evaluate his medical needs?

I watched him shuffle down the hall towards me with an officer. He looked much older than his 59 years. His wrist and ankle shackles startled me. As a geriatrician, I know fall-related injuries are a leading cause of death among older adults<sup>1</sup> - surely shackles increase this risk exponentially. He sat down slowly to keep his balance. I leaned forward attempting to shake his hand, which was awkwardly shackled to his side. He looked at me and offered a wary smile.

"How are you holding up?" I asked. What was I expecting – rage? tears?

"I don't know," he said, in a voice so quiet that I had to strain to hear. "I guess I am hopeful."

It did not seem that he had much to be hopeful for. He had been in solitary confinement since 1972 - almost every day of my entire life. His daily routine included at least 23 hours in a 6-foot by 9-foot cell with little to no human contact punctuated by - at most - an hour's "exercise" in a small outdoor cage three times weekly, alone.

In the decade since meeting Mr. Woodfox, I have spoken with, examined and consulted on dozens of prisoners in solitary confinement, many of them older, nearly all chronically ill. During that time, a growing scientific literature has established the catastrophic psychological impact that solitary confinement can have on juveniles and the mentally ill.<sup>2</sup> In 2012, the American Psychiatric Association recommended against solitary confinement for the mentally ill, in a 2016 Washington Post article, President Obama called for a ban on solitary for juveniles, and in 2016 the U.S. National Commission on Correctional Healthcare decried solitary extending beyond 15 days as cruel, inhumane and harmful.

A growing number of professional bodies (including the American Public Health Association) recommend limiting solitary confinement. But the medical case against its use remains only half-made

- the physical health effects of this practice are under-documented. As a result, an important argument against its widespread use is largely missing.

Nearly 1 in 5 prisoners – about 400,000 individuals – experienced solitary confinement during 2011-2012.<sup>3</sup> For most, solitary confinement is not a legal sentence, but is used at correctional staff discretion. It is generally a punishment for rule violations, although it is sometimes used for protective custody or for those who might pose a risk to others (e.g. gang affiliated).<sup>2</sup>

But what are the physical health effects of being kept for months - years, decades - in a space roughly the size of a parking spot? From a health perspective, these conditions are hazardous at best. Solitary units differ by facility. Generally, isolated prisoners are permitted up to 7-10 weekly hours “out of cell time,” often to choose between showers or exercise in a room no bigger than their cell. Many outdoor exercise units have high concrete walls and partial roofs, some prisoners live for years without seeing the sky. Such a prolonged lack of sunlight can cause Vitamin D deficiency, putting older adults at risk for fractures and falls, a leading cause of hospitalization and death.<sup>1</sup> Moreover, exercise - even the little we get walking from sofa to kitchen to bedroom - is crucial for maintaining health among all ages. It is also an important preventive measure, and sometimes treatment, for many conditions - hypertension, diabetes, arthritis, heart disease among others. These conditions are disproportionately common, at younger ages, among prisoners.<sup>4</sup>

The sensory deprivation of isolation - reductions in auditory or visual stimuli – can worsen mental health in all ages.<sup>2</sup> For older adults, these deprivations can also worsen confusion and memory loss.<sup>1</sup> Locked behind doors, some hearing-impaired individuals cannot engage even in the informal human contact that sometimes occurs in solitary confinement units by yelling through doors and vents. This exaggerates their isolation, which studies show worsens heart disease and hastens death.<sup>5</sup> Others have described a profound visual depth disturbance - the sense that they don't know where the floor is - and the worry that at any minute, they could fall.

As a physician, I subscribe to the fundamental medical ethic of “first, do no harm.” But a lack of transparency and system-wide health data often limits researchers' ability to describe the range of solitary confinement's harms. It is time for a public health call to improve data transparency to evaluate the physical safety of such correctional practices. Given the risk factors for poor health that solitary confinement poses, particularly for those confronting illness or frailty, health professionals should advocate for limits on solitary confinement for older or chronically ill persons, just as we increasingly protect those in juvenile facilities and the mentally ill. Such action should find bipartisan support given the considerable expenses - in healthcare spending and avoidable injury and illness - generated by our criminal justice system.

Extraordinary challenges lie ahead for Mr. Woodfox as he rebuilds his body and soul after an unimaginable physical and psychological ordeal. When Mr. Woodfox gave me permission to write this editorial, we recalled the hope he expressed when we met. Perhaps hope helped him endure the

decades of profound isolation. And perhaps he will be among a decreasing number subjected to our widespread reliance on long-term solitary confinement.

The UN Special Rapporteur for Human Rights has pronounced solitary confinement exceeding 15 days to be torture.<sup>6</sup> As the bipartisan tides of U.S. criminal justice reform swell, many are questioning the use of long-term solitary confinement as never before. A broad public health strategy that considers this practice's health risks for all individuals is critical. Until then, those leading reform efforts for one population at a time (e.g. the mentally ill, juveniles) should also consider older adults and the chronically ill, populations too often ignored in reform efforts whose health would clearly benefit from exercise and social interactions. With an increasingly older and chronically ill prisoner population,<sup>4</sup> it is time for correctional leaders, public health professionals, researchers, and those who have experienced solitary confinement to advocate for the use of alternatives to solitary confinement for all individuals, with a special emphasis on those who are older or chronically ill.

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