Even better data on solitary confinement are needed

In our recent Article in *The Lancet Public Health*,[1] we used Danish register data and a dataset from the Danish and Prison and Probation Service, which provided information on the recorded conditions under which people served a prison sentence in Danish prisons during 2006–11. In this Correspondence, we aim to provide increased clarity around the language we used in our Article and to invite the future production of even better data on solitary confinement than we had access to.

In our Article, we defined the so-called treatment of interest as solitary confinement. Solitary confinement is a broad umbrella term that formally includes a range of types of confinement, including administrative segregation, disciplinary segregation, and protective custody.[2] Yet, because the definition of solitary confinement includes being confined in solitude for 22–23 h a day, other and unrecorded types of de facto solitary confinement are likely to also occur in prisons.[3]

However, our data included information only on recorded disciplinary segregation in punishment cells. Individuals who have experienced solitary confinement for any reason other than disciplinary infractions would thus be included in the so-called control group rather than the so-called treatment group (because other forms of solitary confinement were not recorded in the data). We here refer to treatment and control groups only to specify the comparison groups, our research did not involve randomisation.

Descriptively, this measurement issue means that we substantially underestimated the total prevalence of solitary confinement in Danish prisons because we only measured a subset of all solitary confinement placements. The total share of Danish inmates in open and closed prisons who experienced any solitary confinement was thus much higher than our descriptive statistics for restrictive housing indicated.

Therefore, for the associational portion of our Article—ie, the portion that considered the association between solitary confinement placement and mortality after release—our analysis likely underestimated the strength of the association because the control group included people who did experience solitary confinement placement of which we had no record.

Considering the risk that our associational results are a lower bound of estimation, meaning that the association between any type of solitary confinement and mortality could well be even stronger than what we found, we find it timely to invite future research that seeks to include broader measures of solitary confinement.

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