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INTERIM REPORT ON SERVICES FOR INDIVIDUALS WITH SPMI PLACED IN SOLITARY CONFINEMENT BY THE RHODE ISLAND DEPARTMENT OF CORRECTIONS

April 12, 2017

Introduction

As the designated Protection and Advocacy agency for Rhode Island, the Rhode Island Disability Law Center (RIDLC) is federally authorized to protect and advocate for the rights of persons with disabilities within Rhode Island. Our federal authority allows us to monitor facilities which provide services to persons with disabilities, and to investigate allegations of abuse or neglect of individuals within those facilities. For persons with mental illness, federal law specifically recognizes prisons as facilities that we may monitor and investigate.[1]

Last year, we became aware that the Rhode Island Department of Corrections (RIDOC) had acknowledged employing solitary confinement (disciplinary segregation) on at least thirty-nine (39) inmates with serious and persistent mental illness (SPMI) at the Adult Correctional Institutions (ACI). Citing to a growing legal and clinical consensus against the use of solitary confinement for people with SPMI, we wrote to RIDOC on August 26, 2016 requesting access to those 39 individuals pursuant to our federal authority. We were provided with the names of those inmates confined at the Maximum and High Security facilities of the ACI and conducted interviews obtaining records from 29 of those persons that RIDOC identified as having a SPMI who had been reported by the Department to have been subjected to some form of disciplinary confinement or segregation during the time period of April 7, 2015 through April 7, 2016. With permission from those interviewed, we subsequently sought each person's RIDOC medical records as well as records of disciplinary confinement.[2] Given the voluminous records involved and their retention in different systems within RIDOC, we agreed with the administration to relax the usual strict time frames for response to such requests; to limit the initial response to all medical records and disciplinary segregation summaries for approximately two prior years; and, to produce policies and standard operating procedures (SOP) designated as pertinent to our

[1] The Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act of 1986, 42 U.S.C. §§ 10801 et seq.; 42 U.S.C. § 10802(3). See also 45 C.F.R. § 1386.19.

[2] By letter of November 3, 2016, we sought access to "any and all confidential health care information relating to medical treatment and treatment for mental health/illness. Information to be released shall include treatment plans, physician orders, psychiatric exams, psychological tests, as well as any documents or reports relating to any consultations, evaluations, or check-ups by any personnel of any kind, from the start date provided on each authorization to the present."

request by the RIDOC legal office as well as the index of all RIDOC policies and SOPs. Following that, we also requested additional policies, SOPs, and individual booking reports and further clarifications which are still in process of being produced by RIDOC. To better understand current RIDOC disciplinary practice and behavioral health services, we had discussions with legal and behavioral health staff at RIDOC regarding both the records reviewed and relevant RIDOC policies, practices and procedures.

We also consulted with both legal and clinical experts who are familiar with evolving standards regarding the use of solitary confinement for prisoners with SPMI and mental health treatment protocols within prison systems. A clinical expert with considerable teaching and forensic psychiatry experience and an extensive resume in overseeing prison mental health services helped us to focus our review on the degree to which RIDOC treatment of inmates with SPMI conformed to the standards of the NCCHC National Commission on Correctional Health Care (NCCHC).

The NCCHC is a non-profit organization, whose origins date to the early 1970s, when an American Medical Association study of jails found inadequate, disorganized health services and a lack of national standards. In collaboration with other health, legal and corrections professions organizations, the AMA established a program that in 1983 became NCCHC.[3] The NCCHC publishes health care standards for prisons, and in 2015 issued Standards for Mental Health Services in Correctional Facilities.[4]

The NCCHC also develops position statements on issues not fully covered in its Standards. In April 2016, the NCCHC adopted a Position Statement on Solitary Confinement[5] which operates from a premise that "[i]t is well-established that persons with mental illness are particularly vulnerable to the harms of solitary confinement." The Position Paper adopted 17 principles to guide health care professionals in addressing the issues of solitary confinement. In addition to finding that more than 15 consecutive days in solitary confinement is inhumane and harmful to a person's health, the principles included, inter alia:

- Using solitary confinement only as an exceptional measure when other, less restrictive options are not available, and then for the shortest time possible;
- Isolating inmates for clinical or therapeutic purposes only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible, and only in a clinically designated and supervised area;
- Not involving health staff in determining whether inmates are physically or psychologically able to be placed in isolation;
- Observing principles of medical confidentiality for patients who are in solitary confinement;
- Ensuring as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff; and

[3] *See* http://www.ncchc.org/about (last visited March 25, 2017)
[4] Standards of Mental Health Services in Correctional Facilities, © 2015 NCCHC; *See* http://orders.ncchc.org/core/store/product.aspx?prod=01tF0000004DmWIIA0&cat=CAT-000006 (last visited March 25, 2017)
[5] National Commission on Correctional Health Care. (April 2016) Solitary Confinement (Isolation) (Position Statement) *See* http://www.ncchc.org/filebin/Positions/Solitary-Confinement-Isolation.pdf

- Making appropriate programs available to assist inmates in confinement with the transition to other housing units or the community.

In this Interim Report, we have highlighted information gleaned from inmate interviews and record reviews in an attempt to compare RIDOC practices to specific NCCHC standards. We note that the records we have received from RIDOC may not be complete,[6] and that there may be other relevant RIDOC policies than the ones we have cited. Nonetheless, we hope that our comments can serve as the basis for supporting and strengthening behavioral health services for individuals with SPMI within RIDOC.

Lastly, we want to acknowledge the recent statements made and documents disseminated by RIDOC within the hearings of the Rhode Island General Assembly's House Study Commission on the Use of Solitary Confinement at the ACI, which express an interest in excluding inmates with SPMI from disciplinary confinement and developing alternative interventions for these inmates.

The analysis that follows first lists the relevant NCCHC standard, followed by our comments.

Pre-Segregation Consultation to Corrections Staff

MH-G-06 Discussion: *Mental health staff should offer consultation to disciplinary hearing officers that helps them recognize when mental illness may be a contributor to inmate misconduct. Mental health professionals should be consulted by disciplinary hearing officers when mental illness is suspected prior to a due process hearing.*

MH-E-07 Compliance Indicator 1: *On notification that an inmate is placed in segregation, mental health staff reviews the inmate's mental health record to determine whether existing mental health needs contraindicate the placement or require accommodation. Such review is documented in the clinical record.*

Current RIDOC policy does allow for some form of health consultation to occur, requiring Behavioral Health Services staff to *"check [the computer system] on a daily basis for disciplinary reports issued in their respective facilities."* RIDOC 11.01-6, III, C.2.e (1). If that staff member believes that the inmate's mental health contributed to the booking, they *"may then approach the facility warden to discuss the matter."* Id. The warden, or his or her designee, then has the option of dismissing the charge, referring it to hearing, or reviewing the disciplinary report with the staff member to determine the extent of the contribution of the mental health issue. Id. at C.2.e.(2)(a)-(c).

Other than this, we found no indication through staff interviews or records request that there is any formalized policy or system to affirmatively screen out inmates with known serious and persistent mental illness from such a sanction in the first place, nor other inmates for whom there may be other indications that solitary confinement would possibly cause significant or lasting psychological harm.

[6] e.g. RIDOC has advised us that the segregation status of inmates with SPMI whose disciplinary segregation was curtailed due to illness or behavioral staff input may be reflected in security records as opposed to medical records

While it was reported to RIDLC staff that clinical social workers try to attend disciplinary hearings at Maximum and High Security, it was difficult to ascertain direct references from the records as to any intervention on the part of behavioral health staff prior to due process hearings. From the records of the twenty-nine individual inmates that were reviewed, there were only two instances where it was discernable that behavioral health staff were present although there were another two instances where inmates appeared to have either been transferred to the Forensics Unit of the Eleanor Slater Hospital or placed on crisis management status followed by psychiatric observation without formally completing the booking procedures. Even with the presence of behavioral health workers at disciplinary hearings we saw no direct record indicating that such a presence produced any discernible effect on the results of those proceedings. RIDOC behavioral health staff indicates that in the future they will add references regarding their participation in disciplinary proceedings to medical records.

Of the 401 bookings received by the twenty-nine inmates over the time period reviewed, guilty findings were made in 378 of them. This amounts to a 94% rate of conviction and the vast majority of those guilty findings came with a sanction of disciplinary confinement coupled with loss of good time. Although it was also reported to RIDLC that behavioral health staff often provide consultation to the warden for the purpose of reducing the resulting disciplinary confinement, because of the difficulty in finding any direct reference in the records to this occurring, it is impossible to determine how frequently or how successfully this occurred, and what effect, if any, this may have had.[7]

Time out of cell

MH-E-07 Discussion: *Inmates who are seriously mentally ill should not be confined under conditions of extreme isolation; rather, alternative programs that address underlying mental health problems should be considered.*

NCCHC Position Statement, Principle 2: *Juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.*

In our review of inmate records, we were unable to ascertain if anyone ever received any more than one hour out-of-cell in any twenty-four period of time during disciplinary segregation. Interviews with the inmates themselves confirmed that they were segregated for 23 hours per day. We were made aware that RIDOC is developing policy that increases the number of hours inmates are allowed out of their cells. They have publicly stated, as part of their *"close confinement"* status (essentially, a step-down program), inmates on such a status are let out of their cells between three and six hours a day. See February 23, 2017, RIDOC Inter-office Memorandum, Close Confinement, 1. While we found nothing that documented this policy in our review of records, the records we reviewed preceded the development of this policy.

[7] RIDOC reports that as of April 10, 2017, among the twenty-nine inmates, eighteen were returned to general population; three were in close confinement; one, of choice, was in administrative segregation; one was serving a ten-day disciplinary segregation on a new infraction; four were at Eleanor Slater Hospital; and, two had been released to the community

Mental Health Monitoring of Segregated Inmates

MH-E-07 Compliance Indicator 3: *Monitoring of a segregated inmate is based on the degree of isolation:*

a. *Inmates under extreme isolation with little or no contact with others are monitored daily by medical staff and at least once per week by qualified mental health professionals.*
b. *Inmates who are segregated and have limited contact with other staff are monitored 3 days a week by medical or qualified mental health professionals;*
c. *Inmates who are allowed periods of recreation or other routine social contact among themselves …are checked weekly by a medical or qualified mental health professional.*

It is difficult to apply one single catch-all label to conditions of disciplinary confinement at the ACI. In some cases, inmates under disciplinary confinement have the ability to talk to others, as well as correctional officers; in others, they report being left alone in their cell for the 23 hours of their day. Sometimes inmates are allowed to spend their 45 minutes of recreation time with at least one other inmate in their so-called recreation "cages." However, on other days, most notably weekends and holidays, they are not given this time out of cell at all. In one instance, an inmate at Intake informed RIDLC attorneys that the time he spent meeting with them was being counted as his recreation time for the day.

RIDOC policy requires that mental health evaluations are required, at a minimum, to occur: "(1) On the first business day following an inmate's thirtieth (30th) consecutive day in disciplinary confinement. (2) At least once every thirty (30) days thereafter or before." RIDOC 11.01-6 DOC, III.C.13(d)(1)-(2). There is a significant difference between this 30-day policy and that of NCCHC standards, which requires anywhere between daily and weekly monitoring and assessments of a segregated inmate. It is also important to note we did not see in RIDOC policy any written provision for the dismissal of a disciplinary segregation upon a finding that the inmate's mental health is being impacted. Instead, the policy only allows for the transfer of chronically mentally ill inmates to be placed on a crisis management, or some other form of observational status. *See below*.

As discussed elsewhere, RIDOC Behavioral Staff personnel do report that they go above what they are required to do by policy, with some attempting to make weekly "trips" of the segregated housing, as well as advocating on inmates' behalf when they apply to the warden for review of their sanction. However, we found no documentation to verify a more frequent visitation schedule, beyond the monthly segregation checks, which were, by and large, recorded in the medical files of inmates who had been issued more than 30 days of consecutive disciplinary confinement, at intervals of approximately every 30 days. And, as discussed above, the fact that individual RIDOC personnel may in some cases, for some inmates, for some facilities, go above and beyond what is required by RIDOC policy does not substitute for an actual policy that is uniformly and consistently applied.

The record review of those inmates with SPMI show that, although, in many cases inmates were seen by some member of mental health staff more than once a month, we could not tell if some of the concerns of prolonged isolation were addressed by these auxiliary check-ups or if they necessarily met the stated intent of such standards which is for a mental health professional to

specifically monitor for *"signs of mental and physical decompensation [of those] vulnerable to irritability, anxiety, or depression."* Id. Moreover, in the case of at least one inmate, there was no record of any other treatment or visitation provided by any medical staff member between monthly segregation checks.

Specialized Mental Health Programs and Residential Units.

MH-G-02 Discussion: *The intent of this standard is to establish the principles and practices for mental health programs and residential units offered in correctional facilities."*

MH-G-02: Definitions: Mental Health Programs *are organized outpatient interventions, time-limited or ongoing, that include individual or group interventions for inmates regardless of their housing assignment*

Mental Health Residential Units *provide varying levels of care to meet the needs of the seriously mentally ill. These units can be of two types:*

1. Acute care residential units *are located in dedicated housing areas and offer stabilization and programming as indicated for those who are psychotic, clinically unstable (including acutely suicidal or at imminent risk of self-harm), or waiting for placement into an inpatient psychiatric setting. The goal of an around-the-clock acute care residential unit is to control psychotic symptoms, stabilize the patient, keep the patient safe, and improve activities of daily living.*
2. Nonacute care units *are short-term or permanent housing areas that provide services for those who are chronically mentally ill or experiencing situational stresses. Patients housed in such units typically require a lesser degree of mental health programming and supervision than acute care residential units. Examples of nonacute care units include transitional care units and step-down units.*

MH-G-02: Compliance Indicators:

2. Acute mental health residential units, *when provided on-site, are consistent with their defined scope of care to provide for patients who are psychotic, clinically unstable, acutely suicidal, or at imminent risk of self-harm, and have, at a minimum:*

   a. Continuous (24 hours per day, 7 days per week) coverage by mental health staff assigned to the unit
   b. Orientation and training for correctional officers assigned to the unit
   c. Daily (7 days per week) patient evaluation by mental health staff
   d. Programming or appropriate therapies, if indicated
   e. Individual treatment plans
   f. Housing in a safe and therapeutic environment *conducive to symptom stabilization and maintenance of good personal hygiene.*

3. *Nonacute mental health residential units, when provided on-site, have, at a minimum:*
   a. A defined scope of care
   b. Either programming or appropriate therapies (or both) to meet the mental health needs of patients on the unit

c. Mental health staff of sufficient numbers and kind in keeping with the purpose of the unit.
d. Individual treatment plans
e. Orientation and training for correctional officers
f. A clear, safe, therapeutic environment and milieu, *including facilities for maintaining good personal hygiene with guidance in the* activities of daily living if needed.

RIDOC anti-suicide protocol provides three levels of intervention in the form of an observational status placed on the inmate when staff becomes aware that he "may be demonstrating emotional/psychiatric instability." SOP, 2. Depending on the perceived exigency of the situation, an inmate may either be placed on Constant Observation (which could be in their own cell), Crisis Management Status (observation at 10-minute intervals), or Psychological Observation Status (observation at 30-minute intervals), with the last two statuses requiring transfer to a "suicide resistant cell." Id. at 5.

These observation statuses represent RIDOC's effort to maintain and stabilize those inmates who are at imminent risk of self-harm, as well as those who are "chronically mentally ill or experiencing situational stresses." MH-G-02. Indeed, these statuses do fulfill the same basic purpose by greatly increasing the monitoring of the inmate and receiving multiple mental health assessments per day. We could not tell from the records whether the inmates in any of the 3 levels received the programming or appropriate therapies that the NCCHC standards require for inmates with mental health issues.

RIDOC's crisis intervention appears to simply remove the inmate from any instrument he could use to harm himself and puts him in close and frequent contact with mental health staff. According to policy, inmates on these statuses are allowed all, *"routine privileges (e.g., visits, showers, telephone, out of cell, etc.… unless the inmate has forfeited said privileges as a result of a disciplinary sanction."* Id. at 7. For those who were put on this status concurrently with receiving a booking (or reaching crisis state while already in solitary confinement), this meant that, after return to pre-crisis levels, they were returned to their original state of 23/1 cell time with the exception of two individuals one who was transferred to the Forensics Unit of the state hospital and another who was essentially placed in an ongoing treatment modality within the prison. Indeed, records indicate those who were placed under one of the observation statuses often found themselves placed on it on repeated occasions, with one inmate staying on the status for as long as three months.

As mentioned elsewhere, we are still conducting interviews, acquiring additional records and policy/SOP documents and are anticipating further conversation with RIDOC. However, our review so far appears to reveal an apparent lack of resources for inmates with serious mental health illness or who may be in crisis mode. We are aware that those inmates who are acute and in need of specialized mental health services may be transferred to a more clinical setting at the Forensic Unit of the state hospital; however, we saw only one example of that occurring in the records we reviewed (although we do know that the Forensic Unit has a limited number of beds).

We were unable to see or ascertain if there is any facility within the prison that would meet the NCCHC Mental Health Residential Units standard pertaining to either acute care or nonacute care. RIDOC acknowledged that they are reliant upon the capacity of the state Department of BHDDH Mental Health Services to provide acute care and represented that they are planning to establish a residential treatment unit for nonacute care.

Treatment Plans

MH-G-03 Standard: *Mental health services are provided according to individual treatment plans.*

MH-G-03 Definition: *A* treatment plan *is defined as a "series of written statements specifying a patient's particular course of therapy and the roles of qualified mental health professionals in carrying it out. Such a plan is individualized, may be multi-disciplinary, and is based on an assessment of the patient's needs. It contains a statement of short- and long-term goals as well as the methods by which those goals will be pursued…."*

MH-G-03 Compliance Indicator 5: *Mental health treatment plans include, at a minimum:*

a. *Frequency of follow-up for evaluation and adjustment of treatment modalities*
b. *Adjustments of psychotropic medications, if indicated*
c. *Referrals for psychological testing, medical testing and evaluation*
d. *When appropriate, instructions about diet, exercise, personal hygiene, and adaptation to the correctional environment*
e. *Documentation of treatment goals and objectives, interventions necessary to achieve those goals, and notation of clinical progress.* Id.

In our review of the medical records of these twenty-nine inmates, who had been previously identified as diagnosed with SPMI, we found no documented plan that conformed entirely to this standard. Out of twenty-nine inmate records received, the only noted plans discussed medication management in twenty-seven instances; twenty-three do make reference to at least minimal notations of subjective, objective, assessment, and plan (SOAP); one mentioned non-specific assessment for dementia; one discussed referral for a full psychiatric workup but ignored a significant history of out-of-state mental health treatment and repeated psychiatric hospitalizations; one mentioned other therapies but no evidence of such therapies were found other than periodic occupational therapy and some occasional individual therapy; two indicated issues with medication compliance with one noting only medication refusal and another indicating a history of Petitions for Instructions to the Mental Health Court.

Additionally, although not always found in a documented "plan", there were records that documented that another nine inmates were receiving individual therapy; nine participated in group therapy (but not while in segregation); eleven had occupational therapy (but, it could not be determined if they were able to participate during segregation); and, one of those individuals was documented to have received Dialectical Behavior Therapy while in segregation rather than occupational therapy while the other three were either noted to not have occupational therapy in segregation or it was not possible to ascertain from the records if they continued occupational therapy in segregation or not.

Despite the lack of treatment plan documentation, the medical records of almost all inmates we reviewed contained adjustments of medications and referrals for follow-up medication evaluations. However, such information did not always appear in a document labelled "treatment plan". In fact, of the twenty-nine records reviewed, only four contained a record labelled "treatment plan" with another twenty-four simply labelled, "plan" and one where no "plan" or "treatment plan" was seen (that individual was, however, transferred by court order to the Forensics Unit of the state hospital for specialized services unavailable at the prison. Again,

none of the "plans" or "treatment plans" completely met the criteria of the NCCHC standard for a treatment plan. RIDOC has stated that, as of April 10, 2017, training has commenced to prepare and document treatment plans to meet this standard.

Credentials/Staffing

MH-C-01 Standard*: All qualified mental health professionals have credentials and provide services consistent with the licensure, certification, and registration requirements of the jurisdiction.*

We were unable to establish whether all current clinical staff meets the qualifications of this standard.

RIDOC does employ eleven behavioral health staff for approximately three thousand inmates for a ratio of 1 to 250 considered to be inadequate by any standard that we reviewed or are aware of. And, while acknowledging the provision of occupational therapy, group therapy, and some individual therapy, there appeared to be a consequent dearth of other adequate or appropriate programming and therapies. RIDOC advises that they are seeking additional behavioral health staff that would meet or equal appropriate qualification standards and that future staff should be held to such standards.

Privacy

MH-A-09 Standard: *Discussion of patient information and clinical encounters are conducted in private and carried out in a manner designed to encourage the patient's subsequent use of mental health services.*

MH-A-09 Definition: *Clinical encounters are interactions between patients and mental health care professionals that involve a treatment and/or an exchange of confidential information.*

MH-A-09 Compliance Indicators:

1. *Discussions among staff regarding patient care occur in private, without being overheard by inmates and non-health staff.*
2. *Clinical encounters occur in private, without being observed or overheard.*
3. *"Security personnel are present only if the patient poses a probable risk to the safety of the mental health care professional or others.*
4. *Instruction on maintaining confidentiality is given to security staff and interpreters who observe or hear health encounters.*
5. *All aspects of the standard are addressed by written policy and defined procedures.*

MH-A-09 Discussion: *"[w]hen safety is a concern and full privacy is not possible, the Standards note, it is recommended that alternative strategies for partial visual privacy or partial auditory privacy be considered."*

For inmates specifically in solitary confinement, the NCCHC Position Statement encourages that they be examined "… in clinical areas where privacy can be ensured … without restraints and without the presence of custody staff unless there is a high risk of violence." See NCCHC Position Statement: Solitary Confinement, Principle 13. And when such a risk does necessitate

their presence, they "should maintain visual contact, but remain at a distance that provides auditory privacy." Id.

We were advised by RIDOC mental health personnel that they strive to achieve an appropriate degree of privacy. See e.g., Suicide Prevention SOP, IV.B.3. "Cell-side assessments should be avoided whenever possible, and justified in writing if utilized." RIDOC behavioral staff personnel also reported doing their monthly segregation checks out-of-cell, in a separate office, and nothing was found in the records that would indicate otherwise. However, many inmates reported confidentiality concerns with this setting, complaining that the door was often left open, sometimes with one or more correctional officers standing directly outside of it. Besides the general confidentiality concerns inherent in receiving therapy within earshot of others, inmates also expressed specific concerns about correctional officers hearing, and later discussing, what was overheard.

Although there is a RIDOC policy which covers "Confidentiality of Inmate Health Information to Include Electronic Medical Record (EMR) and Paper Documents" (18.59-5 DOC), this policy covers only the records themselves, and we did not discover any policy which provides guidance as to how health care providers should address confidentially concerns in their meetings with inmates. We did not find and do not know if there is a policy regarding confidentiality for non-health care employees or whether they receive specific training on confidentiality. Additionally, RIDOC acknowledges that seeing inmates in a private setting can at times be limited by lack of security staffing.

Conclusion

Based on RIDOC estimates, we understand that at any given time a significant number (between 15-17%) of the inmates at the ACI have a SPMI.[8] We appreciate that this significant percentage is in large part attributable to community service capacity issues and other events beyond Department's control. We also acknowledge recent statements made by RIDOC at the Rhode Island General Assembly's House Study Commission of the Use of Solitary Confinement at the ACI, which express an interest in excluding inmates with SPMI from disciplinary confinement and developing alternative interventions for this population. We believe the adoption of such policies and procedures as those found in the NCCHC standards and NCCHC Position Statement will support the achievement of this goal by helping to establish the treatment and alternative practices needed by individuals with SPMI. We look forward to supporting their achievement of this goal.

[8] By RIDOC definition, "Serious, Persistent Mental Illnesses" are: Schizophrenia; Schizoaffective disorder; Delusional disorder; psychosis not-otherwise-specified (NOS), and other psychotic disorders; Bipolar disorder, also know as manic-depression; Severe depression that resists treatment and impacts ability to function; Personality disorders that are severe enough to prevent functioning.

APPENDIX: NCCHC National Commission on Correctional Health Care (NCCHC) Position Statement (April, 2016)

Solitary Confinement (Isolation)

DEFINITION

Solitary confinement is the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals. Those in solitary confinement often experience sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs. Different jurisdictions refer to solitary confinement by a variety of terms, such as isolation; administrative, protective, or disciplinary segregation; permanent lockdown; maximum security; supermax; security housing; special housing; intensive management; and restrictive housing units. Regardless of the term used, an individual who is deprived of meaningful contact with others is considered to be in solitary confinement.

INTRODUCTION

In recent years, there has been increasing controversy over the use of solitary confinement in the nations' jails, prisons, and juvenile detention centers. Many national and international organizations have recognized prolonged solitary confinement as cruel, inhumane, and degrading treatment, and harmful to an individual's health. In its position statement on **Correctional Health Professionals' Response to Inmate Abuse**, NCCHC declares:

1. Correctional health professionals' duty is to the clinical care, physical safety, and psychological wellness of their patients.
2. Correctional health professionals should not condone or participate in cruel, inhumane, or degrading treatment of inmates.

This position statement has been developed to assist health care professionals in addressing the use of solitary confinement in the facilities in which they work.

BACKGROUND

Over the last 25 to 30 years, there has been a marked increase in the use of solitary confinement in the United States. A report based on Bureau of Justice Statistics data estimated that approximately 80,000 inmates are held in some form of isolation in state and federal prisons on any given day.[1] Isolation can last for periods of time ranging from days to years, even decades. It can occur in "supermax" prisons and in special housing units within jails and prisons.

Adults and juveniles can be placed in solitary confinement for a variety of reasons, including (1) punishment for not following rules (sometimes as minor as failure to obey an order or talking

back); (2) concerns related to the safety of staff or other inmates, such as the management of known or suspected gang members; (3) their own protection (such as for sex offenders or individuals who are transgender or sexually vulnerable); and (4) clinical or therapeutic reasons. In many cases, individuals with mental health problems who have difficulty conforming to facility rules, but are not violent or dangerous, end up being housed in these units. Continued misconduct related to their underlying mental health issues, which is often exacerbated by their isolation, can result in their being held in solitary confinement indefinitely.

It is well established that persons with mental illness are particularly vulnerable to the harms of solitary confinement. As a result, federal courts have repeatedly found the solitary confinement of the mentally ill to be unconstitutional[2], and in 2012, the American Psychiatric Association adopted a policy opposing the "prolonged" segregation of prisoners with serious mental illness, which it defined as longer than 3 to 4 weeks.[3]

The inherent restriction in meaningful social interaction and environmental stimulation and the lack of control adversely impact the health and welfare of all who are held in solitary confinement.[4,5,6,7,8] While there is a school of thought that suggests that solitary confinement in facilities that meet basic standards of humane care has relatively little adverse effect on most individuals' mental or physical health[9,10], this is not the view of most international organizations. The World Health Organization (WHO), United Nations, and other international bodies have recognized that solitary confinement is harmful to health. The WHO notes that effects can include gastrointestinal and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, profound fatigue, heart palpitations, migraines, back and joint pains, weight loss, diarrhea, and aggravation of preexisting medical problems.[11] Even those without a prior history of mental illness may experience a deterioration in mental health, experiencing anxiety, depression, anger, diminished impulse control, paranoia, visual and auditory hallucinations, cognitive disturbances, obsessive thoughts, paranoia, hypersensitivity to stimuli, posttraumautic stress disorder, self-harm, suicide, and/or psychosis. Some of these effects may persist after release from solitary confinement. Moreover, the very nature of prolonged social isolation is antithetical to the goals of rehabilitation and social integration.

These consequences are especially harmful to juveniles whose brains are still developing and those with mental health problems. In 2012, a task force appointed by the U.S. attorney general concluded:

> Nowhere is the damaging impact of incarceration on vulnerable children more obvious than when it involves solitary confinement.... Juveniles experience symptoms of paranoia, anxiety, and depression even after very short periods of isolation. Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide. One national study found that among the suicides in juvenile facilities, half of the victims were in isolation at the time they took their own lives, and 62 percent of victims had a history of solitary confinement.[12]

Psychologically, children are different from adults, making their time spent in isolation even more difficult and the developmental, psychological, and physical damage more comprehensive and lasting. They experience time differently—a day for a child feels longer than a day to an adult—and have a greater need for social stimulation.[13,14,15,16] The American Academy of Child

and Adolescent Psychiatry has concluded that, due to their "developmental vulnerability," adolescents are in particular danger of adverse reactions to prolonged isolation and solitary confinement.[17]

In a report to the United Nations Human Rights Committee, Juan Méndez, U.N. special rapporteur on torture and cruel, inhuman, and degrading treatment, concludes that juveniles, given their physical and mental immaturity, should never be subjected to solitary confinement. He states that the imposition of solitary confinement of any duration on juveniles is cruel, inhuman, and degrading treatment and violates both the International Covenant on Civil and Political Rights and the Convention against Torture. He asserts, "given their diminished mental capacity and that solitary confinement often results in severe exacerbation of a previously existing mental condition," the imposition of solitary confinement, of any duration, on persons with mental disabilities is cruel, inhuman, or degrading treatment and also violates the Covenant and the Convention.[18]

The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) state that solitary confinement should be prohibited in cases involving children and in the case of adults with mental or physical disabilities when their conditions would be exacerbated by such measures.[19]

International standards established by the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders state that pregnant women should never be placed in solitary confinement as they are especially susceptible to its harmful psychological effects.[20] In addition, placing these women in isolation impedes their access to necessary and timely prenatal care.[21]

The U.N. special rapporteur further asserts that solitary confinement is a harsh measure that may cause serious psychological and physiological adverse effects on individuals regardless of their specific conditions. He finds solitary confinement to be contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society. He recommends a complete ban on prolonged or indefinite solitary confinement, citing 15 days as the starting point of prolonged solitary confinement because, after that, "some of the harmful psychological effects of isolation can become irreversible."[22] The Mandela Rules affirm that solitary confinement "shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review…." They specifically prohibit indefinite and/or prolonged (defined as a time period in excess of 15 consecutive days) solitary confinement, or placement in a dark or constantly lit cell, noting that these conditions amount to "torture or other cruel, inhuman or degrading treatment or punishment."[23]

By virtue of working in facilities where security and control, rather than the health and well-being of their patients, are the priorities, health professionals working in correctional facilities are often faced with ethical dilemmas. The participation of health care staff in actions that may be injurious to an individual's health is in conflict with their role as caregivers. This is especially true when they are called on to determine whether a patient is physically and psychologically well enough to be placed in solitary confinement. By doing so, health care providers become participants in the process of solitary confinement. Both the United Nations and the WHO are

opposed to such involvement on ethical grounds. The U.N. has stated that it is a contravention of medical ethics for health care staff, particularly physicians:

> To certify, or to participate in the certification of, the fitness of prisoners or detainees for any form of treatment or punishment that may adversely affect their physical or mental health and which is not in accordance with the relevant international instruments, or to participate in any way in the infliction of any such treatment or punishment which is not in accordance with the relevant international instruments.[24]

The WHO states health care staff should never participate in enforcing any sanctions or in the underlying decision-making process, as this is not a medical act, and:

> Doctors may frequently be approached when the sanction considered is solitary confinement. Solitary confinement has clearly been shown to be injurious to health. In cases where it is still enforced, its use should be limited to the shortest time possible. Thus, doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment. Prisoners who are placed in isolation should be evaluated initially and periodically for acute mental illness, drug or alcohol withdrawal and injuries. If these are identified, prisoners should have access to prompt and effective treatment. Doctors should not certify fitness for isolation.[25]

At the same time, health care staff must ensure that those in solitary confinement have access to and receive needed clinical care. As stated in the European Prison Rules (2006):

> Medical practitioners or qualified nurses should not be obliged to pronounce prisoners fit for punishment but may advise prison authorities of the risks that certain measures may pose to the health of prisoners. They would have a particular duty to prisoners who are held in conditions of solitary confinement for whatever reason: for disciplinary purposes; as a result of their "dangerousness" or their "troublesome" behaviour; in the interests of a criminal investigation; at their own request. Following established practice, (see for example Rule 32.3 of the UN Standard Minimum Rules for the Treatment of Prisoners) such prisoners should be visited daily. Such visits can in no way be considered as condoning or legitimising a decision to put or to keep a prisoner in solitary confinement. Moreover, medical practitioners or qualified nurses should respond promptly to request for treatment by prisoners held in such conditions or by prison staff.…[26]

The WHO also states:

> Once a sanction is enforced, doctors must follow the prisoner being punished with extreme vigilance. It is well-established that solitary confinement constitutes an important stressor and risk, notably of suicide. Doctors must pay particular attention to such prisoners and visit them regularly of their own initiative, as soon as possible after an isolation order has taken effect and daily thereafter, to assess their physical and mental state and determine any deterioration in their well-being. Furthermore, doctors must immediately inform the prison management if a prisoner presents a health problem.[27]

While correctional health care providers often encounter obstacles in the performance of their duties, there are specific challenges to the provision of health care to individuals in solitary confinement. Solitary confinement often makes it more difficult for patients to access care. Many facilities require that individuals in solitary confinement be shackled and accompanied by two officers when they are out of their cells. Many times, they must be body searched upon leaving and returning to their cells. As a result, health care staff may decide to perform their evaluations at cell-front, through bars or slots in the doors, either for their own or the patient's ease. Alternatively, clinical encounters may occur with the patient in a metal cage or behind a glass partition. Even when patients are taken to the medical clinic for evaluation, they often remain in restraints with custody officers in close proximity. Such arrangements are not respectful of an individual's dignity, interfere with privacy and confidentiality, and hamper or prevent the clinician from performing an adequate evaluation.

POSITION STATEMENT

The following principles are to guide correctional health professionals in addressing issues about solitary confinement.

1. Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health.

2. Juveniles[28], mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.

3. Correctional health professionals should not condone or participate in cruel, inhumane, or degrading treatment of adults or juveniles in custody.

4. Prolonged solitary confinement should be eliminated as a means of punishment.

5. Solitary confinement as an administrative method of maintaining security should be used only as an exceptional measure when other, less restrictive options are not available, and then for the shortest time possible. Solitary confinement should never exceed 15 days. In those rare cases where longer isolation is required to protect the safety of staff and/or other inmates, more humane conditions of confinement need to be utilized.

6. Correctional health professionals' duty is the clinical care, physical safety, and psychological wellness of their patients.

7. Isolation for clinical or therapeutic purposes should be allowed only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible, and should take place in a clinically designated and supervised area.

8. Individuals who are separated from the general population for their own protection should be housed in the least restrictive conditions possible.

9. Health staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation.

10. Individuals in solitary confinement, like other inmates, are entitled to health care that is consistent with the community standard of care.

11. Health care staff should evaluate individuals in solitary confinement upon placement and thereafter, on at least a daily basis. They should provide them with prompt medical assistance and treatment as required.

12. Health care staff must advocate so that individuals are removed from solitary confinement if their medical or mental health deteriorates or if necessary services cannot be provided.

13. Principles of respect and medical confidentiality must be observed for patients who are in solitary confinement. Medical examinations should occur in clinical areas where privacy can be ensured. Patients should be examined without restraints and without the presence of custody staff unless there is a high risk of violence. In situations where this cannot occur, the patient's privacy, dignity, and confidentiality should be maintained as much as possible. If custody staff must be present, they should maintain visual contact, but remain at a distance that provides auditory privacy.

14. Health care staff should ensure that the hygiene and cleanliness of individuals in solitary confinement and their housing areas are maintained; that they are receiving sufficient food, water, clothing, and exercise; and that the heating, lighting, and ventilation are adequate.

15. Adults and juveniles in solitary confinement should have as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff.

16. Appropriate programs need to be available to individuals in confinement to assist them with the transition to other housing units or the community, if released from isolation to the community.

17. In systems that do not conform to international standards, health care staff should advocate with correctional officials to establish policies prohibiting the use of solitary confinement for juveniles and mentally ill individuals, and limiting its use to less than 15 days for all others.

Adopted by the National Commission on Correctional Health Care Board of Directors
April 10, 2016

NOTES

1. Shames, A., Wilcox, J., & Subramanian, R. (May 2015). **Solitary confinement: Common misconceptions and emerging safe alternatives**. Vera Institute of Justice.

2. See, e.g., Madrid, 889 F. Supp. at 1265-66; Ruiz v. Johnson, 37 F.Supp.2d 855, 915 (S.D. Tex. 1999), 243 F.3d 941 (5th Cir. 2001), adhered to on remand, 154 F.Supp.2d 975 (S.D. Tex. 2001).

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18. Méndez, J. (2011). **Torture and other cruel, inhuman or degrading treatment or punishment**. Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment (p. 21).

19. United Nations. (May 2015). **United Nations standard minimum rules for the treatment of prisoners (the Mandela Rules)** (Rule 45).

20. United Nations. (2010). **United Nations rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok rules)**.

21. ACLU Foundation. (2014). **Worse than second-class: Solitary confinement of women in the United States**.

22. United Nations. (May 2015). **United Nations standard minimum rules for the treatment of prisoners (the Mandela Rules)** (p. 13).

23. Op. cit. (Rules 43 & 44).

24. United Nations Office of the High Commissioner for Human Rights. (1982). **Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment**.

25. World Health Organization. (2007). **Health in prisons: A WHO guide to the essentials in prison health** (p. 36).

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