Social Justice Brief

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Solitary Confinement:
A Clinical Social Work Perspective

The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty.

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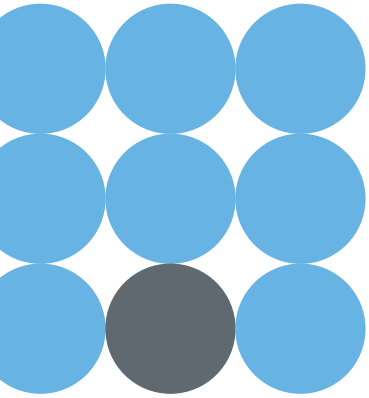
The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world, with nearly 130,000 members. NASW works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.



Solitary Confinement:
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As a nation, we seem to be moving towards comprehensive reform of our criminal justice systems. Many of us are cautiously optimistic that the nation has begun to pay attention to the inequalities—in terms of race, culture and socioeconomic status—of our criminal justice system. Of the many areas of the criminal justice system in need of reform, changes in the way we use solitary confinement stands out as a priority.

Segregating inmates from the general populations of prison, jail or juvenile detention facilities is not new. The first documented use of this practice in a correctional facility was in 1829 at Eastern State Penitentiary in Philadelphia (http://n.pr/1OGVJvK). Since that time, federal, state and local departments of corrections have institutionalized administrative and disciplinary segregation as an acceptable policy throughout the country.

However, in recent years, criminal justice reform advocates, social justice activists, and some government officials have made the country aware of the significant toll the use of solitary confinement has on those who have been subjected to the practice. Perhaps the most alarming aspect of how the use of solitary confinement has evolved over the years is the many cases of prolonged isolation of those with serious mental illness.

To quote social psychologist Craig Haney, "…there was increasing numbers of mentally ill prisoners coming into the prison system. Their behavior was harder to understand; it was harder to control. Prison systems didn't have the resources to properly deal with them, and so solitary confinement increasingly became a repository for mentally ill prisoners who the prison system believed it couldn't control any other way." (http://to.pbs.org/1TM8llj)

While social workers are engaged in the conversation about the need to reform the use of segregation at the federal, state, and local level, this particular social justice brief is on the severe and often life-altering mental health consequences of prolonged segregation and isolation. Social workers are major part of the professional mental health workforce in the United States, especially in serving low-income and marginalized populations. Therefore, the primary objective of this discussion is to examine the problem from a mental health perspective, and to examine the role that social workers can play in providing clinical services both within correctional institutions and in community-based settings.

What is Solitary Confinement?

Solitary confinement is more commonly referred to as *restrictive housing, segregated housing and Special Housing Units* (SHU) by most departments of correction. In fact, in some cases the term solitary confinement can be somewhat of a misnomer in that in a number of federal and state jurisdiction, two inmates are placed in a single cell within a segregation cell block.

However, confining two inmates in a single isolated cell does not mitigate the possible harmful effects of segregation. In fact, it may have the opposite effect by exacerbating psychiatric symptoms related to isolation.

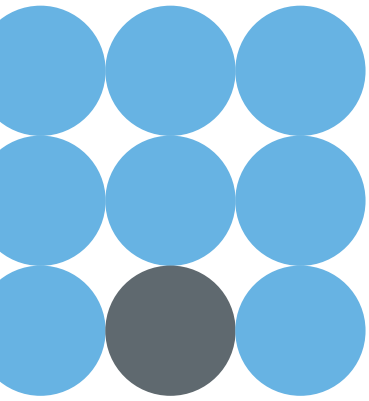
Generally, inmates are put in segregation units for **disciplinary** and **administrative** reasons. According the federal Bureau of Prisons (BOP) definition, **disciplinary segregation** is a form of separation from the general population for a specified period of time. The Discipline Hearing Officer (DHO) imposes disciplinary segregation for inmates who have committed serious violations of BOP rules. The DHO can impose the sanction of disciplinary segregation if it is determined that no other available course of action will adequately punish that inmate to deter them from violating BOP rules again (http://bit.ly/1UFu3az).

Administrative segregation is a form of separation from the general population used when the continued presence of the inmate within the general population would pose a serious threat to the institution's security. Those placed in administrative segregation include inmates who require protective custody; those that cannot be placed in local population because they are traveling to another institution (holdovers); and those who are awaiting a hearing before the Unit Discipline Committee (UDC) (http://bit.ly/1UFu3az). BOP guidelines require that administrative detention is to be only for short-term periods except when an inmate needs long-term protection or where there are exceptional circumstances (http://bit.ly/1UFu3az).

National Data on Extent of Restrictive Housing

Data on the number of persons being held in segregated housing can be illusive. However, according to *Solitary Watch*, 80,000 to 100,000 inmates experience administrative or disciplinary segregation on any given day in the country's prisons, jails, or juvenile facilities (http://bit.ly/21G5EXO). Of that number, 8,625 are federal prisoners (nearly 5 percent of the total federal prisoners). Significantly, close to 1,100 of them were isolated for more than 90 days (http://usat.ly/1RVBQn3).

Based on a Bureau of Justice Statistics (BJS) report, nearly 20 percent of federal and state prisoners and 18 percent of local jail inmates have spent time in restrictive housing. On an average day, 4.4 percent of those in prisons and 2.7 percent of those in jails were in restrictive housing, including disciplinary and administrative segregation. Demographically, the report suggests racial and ethnic disparities in the application of restricted and isolated housing. For example in 2011, 16 percent of white inmates in prisons were placed in such housing. During the same period, 20.8 percent of black prisoners were in restricted housing, and 16 percent of Hispanic inmates served time in solitary confinement. However, when we combine black and Hispanic demographics, we see that at any point in time 36.8 percent of



prison inmates of color spent time in isolation during 2011 (http://1.usa.gov/1kY66z7).

Use of Segregation among Juveniles

As of 2011, the Department of Justice reported that 61,423 minors were being held in 2,047 juvenile facilities, of which roughly one in five used isolation. Some prison officials prefer euphemistic terms like "reflection cottages" or "timeouts." That did not account for adult prisons and jails, which held roughly 95,000 more juveniles, according to an American Civil Liberties Union/Human Rights Watch estimate (http://bit.ly/1Snj4p6).

While juveniles are often placed in solitary for their own protection, the experience of confinement is particularly damaging to young people. A 2012 Human Rights Watch report notes: "Youth offenders often spend significant amounts of their time in U.S. prisons isolated from the general prison population. Such segregation can be an attempt to protect vulnerable youth offenders from the general population, to punish infractions of prison rules, or to manage particular categories of prisoners, such as alleged gang members. Youth offenders frequently described their experience in segregation as a profoundly difficult ordeal."

It has been reported that juveniles are 36 times more likely to commit suicide in an adult jail than a juvenile detention facility and 19 times more likely to kill themselves in isolation than in general population. In the juvenile justice system, approximately half of all suicides take place when a young person is held in "room confinement" (http://solitarywatch.com/facts/faq/).

Mental Health Status of Persons in Restrictive Housing
Source: DOJ-Bureau of Justice Statistics

	% of Inmates		% that spent time in restrictive housing	
	Prisons	Jails	Prisons	Jails
Current Mental Health Status				
No Mental Illness	67.2%	51.5%	15.1%	14.5%
Anxiety Disorder	18.2	22.2	23.3	19.5
Serious Psychological Stress	14.6	26.2	28.9	22.2
History of Mental Health Problems				
Ever been told by a mental health professional you had a mental health disorder?				
Yes	36.6%	43.7%	25.7%	23%
No	63.4	56.3	14.4	13.2
Had a stay in a psychiatric hospital within a year before current incarceration?				
Yes	8.9%	12.8%	30.6%	24.9%
No	91.1	87.2	17.4	16.4
Ever receive professional mental health therapy?				
Yes	35.7%	39.2%	25.5%	22.9%
No	65.3	60.8	14.7	14

Mental Health Implications of Prolonged Isolation

The 2011 BJS data are interesting because they provide a snap-shot of persons with possible existing and pre-existing mental illness prior to being placed in restrictive housing. For example, the data indicates a significant percentage of prison and jail inmates have been in mental health treatment prior to being incarcerated. Perhaps more worrying is that a high percentage of the inmates in this survey who have spent time in isolation have had periods of hospitalizations for psychiatric reasons.

While the Bureau of Justice Assistance (BJA) statistics were based on a self-reporting survey, they are useful in providing a picture of the degree to which mental illness is a key variable (along with race and gender) in developing a profile of characteristics of the average person confined to a segregation unit. The BJA report recognizes that mental health status is an important data element to track. The report is also is useful because it separates the data for prisons and jails. It is

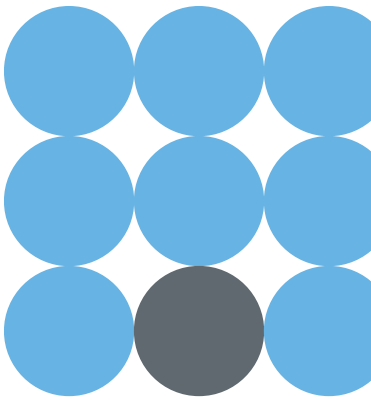
hoped that BJA continues its efforts to collect data on overall mental illness in prisons and jails, and to analyze the intersection between mental illness and periods of isolation. For instance, a key issue for analysis is the degree in which isolation can exacerbate pre-existing mental illnesses, and the extent to which segregated housing precipitates mental health symptoms in those without a reported pre-existing mental health issue before being in isolation.

Other Mental Health Research

There is a growing body of research that shows inmates exposed to prolonged or frequent isolation can also be subject to a host of acute and chronic mental health conditions.

In a 2006 report entitled *Psychiatric Effects of Solitary Confinement*, the author concluded that restricting inmates from normal social interaction can produce conditions such as impairments in perception and cognition, as well as disturbances in affect (http://bit.ly/1OYwr7T). The authors go on to say that in more severe cases, individuals may become confused, psychotic, and have feelings of intense agitation, fearfulness, and disorganization. The report suggests that inmates who experience isolation could manifest long-term or permanent psychiatric impairments that could hamper their ability to reintegrate into the community after release from prison (http://bit.ly/1OYwr7T). A separate 2003 report by Human Rights Watch also found that anywhere from one-fifth to two-thirds of prisoners in solitary confinement have some form of mental illness ((http://to.pbs.org/1OH0HIG).

A 2014 study published in the *American Journal of Public Health*, "Solitary Confinement and Risk of Self-Harm Among Jail Inmates," analyzes the medical records of more than 134,000 prisoners, with a combined 245,000 incarcerations, over the period 2010-2013. Among the population of prisoners studied, about 56.1 percent were non-Hispanic Black, 31.6 percent were Hispanic and 8.4 percent were non-Hispanic white. The study's findings conclude:



- Solitary confinement was "strongly associated" with increased risk of self-harm. Inmates who had been assigned to solitary confinement were 3.2 times as likely to commit an act of self-harm per 1,000 days during their incarceration as those never assigned to solitary;
- Inmates assigned to solitary were 2.1 times as likely to commit acts of self-harm during the days that they were actually in solitary confinement and 6.6 times as likely to commit acts of self-harm during the days that they were not in solitary confinement, relative to inmates never assigned to solitary confinement;
- After controlling for length of jail stay, serious mental illness, age and race, the researchers determined that prisoners punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm; and

Mental Health Symptoms and Diagnoses Precipitated by Isolation in Restrictive Units

Clinical Depression	Paranoia -Psychosis	Hallucinations	Anxiety-Panic Attacks
Hypersensitivity to Noises and Smells	Confused Thought Processes	Out Bursts of physical threats to self, others and objects	Irritability
Cognitive Disturbances	Poor Attention Span	Poor Concentration	Fear of Impending Death
Disorientation to time and space	Poor Impulse Control	Hopelessness and Social Withdrawal	Apathy-Lethargy

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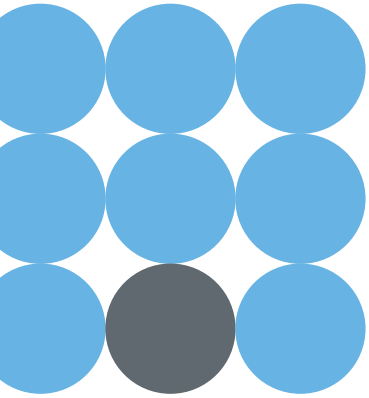


» Of all cases analyzed, four percent involved inmates who were diagnosed with a serious mental illness (http://bit.ly/20rEvtH).

Post Incarceration Syndrome (PICS)

Another mental health concept that is relevant to responding to adults and juveniles who have spent time in isolation is *Post Incarceration Syndrome (PICS)*. PICS is a set of symptoms that affect currently incarcerated and recently released prisoners that are caused by being subjected to prolonged incarceration with few opportunities for education, job training, or rehabilitation. The symptoms are most severe in prisoners subjected to prolonged solitary confinement and severe institutional abuse (http://bit.ly/1o9AicX).

The Post Incarceration Syndrome (PICS) has four clusters of symptoms:

» **Institutionalized Personality Traits** resulting from the common deprivations of incarceration, a chronic state of learned helplessness in the face of prison authorities, and antisocial defenses in dealing with a predatory inmate milieu,
» **Post-Traumatic Stress Disorder (PTSD)** from both pre-incarceration trauma and trauma experienced within the institution,
» **Antisocial Personality Traits (ASPT)** developed as a coping response to institutional abuse and a predatory prisoner milieu;
» **Social-Sensory Deprivation Syndrome** caused by prolonged exposure to solitary confinement that radically restricts social contact and sensory stimulation;
» **Substance Use Disorders** caused by the use of alcohol and other drugs to manage or escape the PICS symptoms.

PICS can also co-occur with substance use disorders and other affective or personality disorders. The importance of clinicians incorporating PICS diagnostic concept in their work with formerly incarcerated individuals is that PICS recognizes the long-term consequences of incarceration (especially if it includes periods of exposure to restrictive housing). The PICS model helps clinical social workers and other behavioral health providers to complete a more in-depth mental health assessment that captures PICS related histories (http://bit.ly/1o9AicX).

Human Development Issues Unique to Juveniles

We should mention that in addition to the mental health risks that prolonged isolation poses for adults, juveniles are subject to additional risks related to human growth and development. During adolescence and into the mid-twenties the human brain grows significantly (http://bit.ly/1X0fGzm). Brain science indicates that the development of the frontal lobe is different in the brains of adolescents and young adults. This is important because the frontal lobe is responsible for cognitive processing, such as planning, strategizing, and organizing thoughts and actions (http://bit.ly/1X0fGzm). Also a section of the brain called the dorsolateral prefrontal cortex is one of the last brain regions to mature. That particular part of the brain is linked to impulse control, ability to internally assess consequences of ones' actions, ability to prioritize, and to strategize (http://bit.ly/1X0fGzm).

Therefore, because key stages of brain development is far from complete during adolescence, juveniles that are placed in

isolation even for short periods of time are ill-equipped to emotionally tolerate such experiences. Young people are disproportionately affected by the trauma and deprivations of solitary confinement and isolation (http://bit.ly/1X0fGzm).

Implications for Social Work Practice

Social work is a national stakeholder in quest for reforms in the use of solitary confinement. We are stakeholders on two levels. One level is social justice/human rights in the context of the National Association of Social Workers (NASW) values. Social workers also make up a major segment of the nation's mental health treatment workforce. Because clinical social workers tend to be employed in government and non-governmental settings whose client base in composed of a low-income, vulnerable population, it is highly likely that they provide services to current and former incarcerated individuals.

To put the significance of the social work behavioral health workforce in perspective, the Bureau of Labor Statistics (BLS) identified approximately 109,500 social workers who specialize in behavioral health practice (mental health or substance use disorder) in the United States. A large number of these social workers work in behavioral health settings where there are clients who include formerly incarcerated adults and/or adjudicated youth and their families. Many of these consumers will have experienced incarceration and possibly have spent time in disciplinary or administrative isolation while incarcerated (http://1.usa.gov/1SVRIGk). Given the BLS employment data on behavioral health social workers, the profession has a role and responsibility to embrace the fact that many of their clients will have histories of justice or juvenile justice involvement.

Social Workers in Behavioral Health Fields

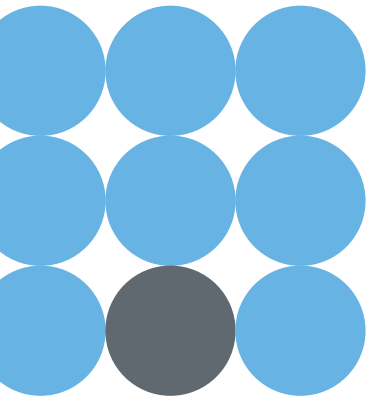
- **Outpatient Care Centers: 23,260**
- **Individual and Family Services: 16,180**
- **Residential Intellectual and Developmental Disability, Mental Health, and Substance Abuse Facilities: 15,850**
- **Local Government: 12,820**
- **Psychiatric and Substance Abuse Hospitals: 8,690**

(http://1.usa.gov/1SVRIGk)

On the strengths of emerging credible research, clinical social workers and other mental health specialists now have better tools to develop treatment and discharge plans that capture key trauma-related histories. Best practices in the form of revised risk assessment and psychiatric assessment tools must also become an integral part of evolving best practice models for justice involved adults and youth. In order to develop best practices for criminal justice social work, practitioners must become informed about the compendium of new data about mental health problems associated with prison life and solitary confinement. Their becoming informed about PICS is not dissimilar from the necessity that mental health providers become *trauma-informed* to better treat clients that experienced early childhood trauma.

Relationship between Public Safety and Early Intervention and Continuity of Care

Many are convinced that there is a nexus between increased public safety and providing mental health prevention services, early mental health intervention (including psychopharmacology), and ensuring



continuity of care through linking the inmate to community-based care, and follow-up communication with community-based providers to ensure the referred returning citizen has made contact with treatment providers. Some of the public safety implications of successful mental health interventions for persons impacted by segregation include:

- Reduction of re-arrests (especially for returnees from jail);
- Reduction of recidivism;
- Mitigating mental health crisis in those with serious mental illness that often lead to dangerous police encounters;
- Providing for emotional stabilization that aids successful long-term

The implications of widespread use of restrictive housing on practitioners is that many must plan for the possibility that some of these clients will have a need for long-term mental health and psychosocial support after their release.

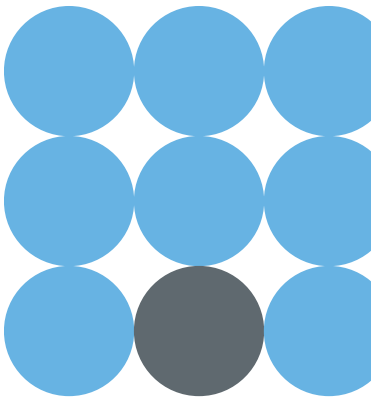
Movement toward Reforms by Federal and State Departments of Correction

The lengthy discussion of the clinical aspects of restrictive housing policy and practice implications is not meant to suggest that we are acquiescing to the status quo of solitary confinement. We are simply recognizing that many thousands of adults and adolescents have already gone through that experience, and will have current and continued needs for mental health services. At the same time, we advocate for major reforms in the system of administrative and disciplinary segregation. That is not to say that federal, state and local governments have ignored the national outcry against solitary confinement. President Obama first raised the issue in a 2015 speech to the National Association for the Advancement of Colored People (NAACP) when he said solitary confinement is "not smart" and "not going to make us safer" (http://bit.ly/1nY05Vx). More recently in January of 2016, the president issued an executive action with banned juvenile solitary confinement in federal facilities. In that same action, he also limited the use of practice for some non-violent adult inmates in federal prisons (http://wapo.st/1QQtPNb).

It is important that we also acknowledge that state correctional systems across the country have begun to initiate reforms in the use of segregated housing which includes examining alternatives to segregation for the mentally ill. It is hoped that the states follow President Obama's lead by completely ending the practice in their juvenile detention facilities. A number of states have already begun to do so, including:

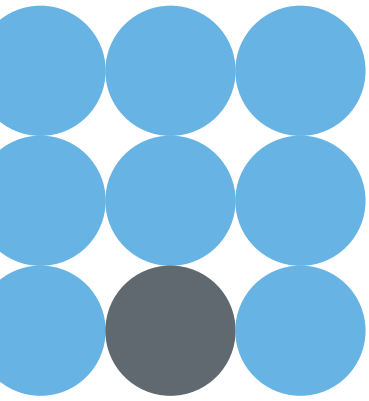
- The **Illinois Department of Corrections (IDOC)** closed its supermax prison, Tamms Correctional Center, which was designed to house prisoners in complete isolation.
- As a result of a government study, the **Maine Department of Corrections** recommended tighter controls on the use of special management units (SMUs). Due to subsequent reforms, the SMU population was cut by more than 50 percent; expanded access to programming and social stimulation for prisoners was implemented; and personal approval of the Commissioner of Corrections is now required to place a prisoner in the SMU for longer than 72 hours;

- **Mississippi** reduced the segregation population of one institution from 1,000 to 150 and eventually closed the entire unit;
- **Michigan** reformed administrative segregation practices through incentive programs that reduced the length of stays in isolation, the number of prisoners subject to such segregation, and the number of incidents of violence and other misconduct;
- The **New Mexico** state legislature mandated a study on solitary confinement's impact on prisoners, its effectiveness as a prison management tool, and its costs;
- **Texas** similarly commissioned a study on the use of administrative segregation in the Texas Department of Criminal Justice, including the reasons for its use, its impact on public safety and prisoner mental health, possible alternative prison management strategies, and the need for greater reentry programming for the population (http://bit.ly/1Pm9Ti7);
- The **Colorado Department of Correction,** with support from the state legislature and advocates, initiated legislation forbidding the placement of seriously mentally ill offenders in long-term isolation. By January of 2014, all offenders designated as having a serious mental illness were evaluated and moved out of administrative segregation to either a residential treatment program or a general population setting. The Colorado DOC determined that the program's success was based on developing effective interventions such as group therapy and one-on-one therapy sessions lead by mental health clinicians. The success of the program also depended on clinical and line staff collaborating to provide individualized support for mentally ill inmates. The Centennial Correctional Facility Residential Treatment Program is a 240-bed program that houses male inmates with chronic mental health illness requiring long treatment (http://1.usa.gov/1OcqA1v).
- **California** recently agreed to an overhaul of the use of solitary confinement in its prisons, including strict limits on the prolonged isolation of inmates. The settlement significantly reduces the number of inmates held in the state's isolation units each day. Nearly 3,000 inmates are kept in segregated units. Under the settlement, prisoners will no longer be sent to isolation indefinitely. And gang members will no longer be sent to solitary confinement based solely on their gang affiliation; only inmates found guilty of serious prison infractions like violence, weapons, narcotics possession. The state will create a new unit for prisoners who are deemed too dangerous to return to the general population. There, they will have more privileges than in solitary, including more time out of their cells, small group leisure activities, and some job opportunities and phone calls (http://nyti.ms/1PmbhBk).



Professional Ethical Implications in Practicing in a Solitary Confinement Setting?

Within the professional clinical provider community there are those who suggest that practitioners (including social workers) who work in settings where restrictive housing exists could be ethically compromised. In an article posted by Human Rights Watch (HRW) the question of professional ethics vis-a-vis solitary confinement was rhetorically raised as follows: "If health professionals simply do their rounds but say nothing, are they implicitly legitimizing the segregation of mentally ill



prisoners and thereby contributing to the continuation of the harm?" (http://bit.ly/1JDH0Bs). The authors answered that ethical question by stating, "We believe it is ethical for physicians to treat prisoners who have been abused, but they must also take measures to end the abuse. In addition to providing whatever services they can to segregated patients, they should advocate within the prison system for changed segregation policies and, if that fails, they should undertake public advocacy." (http://bit.ly/1JDH0Bs).

The position on professional ethics taken in the HRW article would seem to be applicable and reasonable for all treating professionals whose credentials are governed by a Code of Ethics. The primary focus of the social justice brief is on clinical social workers' duty and responsibility to offer quality services to incarcerated and formerly incarcerated individuals who have mental health symptoms as a result of having been placed in restrictive housing. As suggested in the article, there is no contradiction in working in a correctional facility (where restrictive housing policies exist) and also being a vocal advocate for fair and humane policies for managing inmates in such housing.

Thanks to the advocacy of many who recognized immediate need for reforms in the use of disciplinary and administrative segregation, we have seen improvements in managing prisoners with mental illness. In most cases these improved approaches have been achieved without endangering fellow prisoners or staff.

Conclusion

Professional mental health provider organizations such as NASW should be sensitive to perceived ethical concerns associated with practitioners working in a prison, jails and juvenile facilities where segregation is routine. However, NASW should reinforce the fact that the primary obligation of clinicians who practice in such settings is to provide effective and quality mental health treatment to those segregated inmates with mental illness. At the same time, clinicians should be encouraged to work to change harmful segregation policies and practices (http://bit.ly/1JDH0Bs).

It is also critical that social workers, other mental professionals, solitary confinement reform advocates and federal and state officials join together to eliminate the harm that isolating inmates can cause. While it is important that we recognize and applaud the states and jurisdictions that have begun reforms, we should work in partnership with government to develop national standards for housing inmates in segregated units. Such standards should include (but not limited to) the following:

- Develop uniform standards on the use of segregation with an emphasis on:
  - Developing and implementing alternatives to segregation;
  - Guidelines for managing persons with pre-existing serious mental illness and those who have an onset of serious mental illness while incarcerated;
  - Recognize that depression and anxiety can be serious mental health conditions that should be taken into consideration before placing individuals in segregation;

- Prohibit releasing inmates directly from segregation to the community without a clinical assessment of any possible mental and physical health problems as a result of being in isolation;
- Social workers who work in community-based programs that help serve justice– and juvenile justice–involved clients must access training and continuing education that addresses the long-term mental health issues that stem from prolonged and/or highly traumatic responses to the experience of isolation;
- Social workers along with other mental health professionals must begin to integrate trauma-informed modalities into their work with vulnerable populations that have been exposed to stressful life events such as solitary confinement;
- Significantly reduce the use of juvenile segregation beyond temporary crisis situations where there is an imminent danger to self and others;
- Recognize that a number of federal, state and local jurisdictions have and are making efforts to adopt therapeutic responses to housing seriously mentally ill; and
- Support the position that non-correctional mental health practitioners (including social workers) should seek out training and continuing education to learn about the unique clinical challenges that address correctional clinicians such as monitoring and treating seriously ill patients that have been in isolation long period of time (http://bit.ly/1JDH0Bs).

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NASW Resources

NASW » SocialWorkers.org

NASW Foundation » NASWFoundation.org

NASW Press » NASWPress.org

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NASW Center for Workforce Studies » Workforce.SocialWorkers.org

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