

Solitary Confinement and Mental Illness: Ethical Challenges for Clinicians; In Response to Glowa-Kollisch et al.

Thomas R. Blair

Keramet A. Reiter

Published July 2, 2015

To the Editors:

Glowa-Kollisch and colleagues present a well-considered and pragmatically impactful examination of “dual loyalty” concerns for mental health professionals in New York City jails.[1]

We appreciate their particular focus on solitary confinement, and their recognition that “many institutions employ health and mental health services expressly to maintain the practice of solitary confinement.” However, we wish to raise two unexamined issues that are crucial to both the context and the implications of their study: first, the historical basis of trans-institutionalization of mentally ill law-breakers, from psychiatric to penal facilities; and second, the ethical complexity of health care provider abstentions in institutions with limited transparency or accountability. The latter issue particularly contrasts with physician abstention from participation in executions, in which procedures are relatively public and judicially reviewed, as opposed to solitary confinement, which remains a product of administrative discretion, exercised largely without supervision or checkpoints.

First, regarding trans-institutionalization, we have argued elsewhere that solitary confinement and incarceration of seriously mentally ill people in the United States are not merely an ethical danger zone, but rather are historically inextricable and mutually perpetuated.[2] The past five decades in the United States have seen drastic reductions in psychiatric institutionalization, with concomitantly drastic increases in incarceration. While psychiatric deinstitutionalization was intended, at least nominally, to liberate and empower those suffering from serious mental illness, the promises of 1963’s Community Mental Health Act went unfulfilled.[3] In general, psychiatric hospitals were functionally replaced not by community mental health centers, but by jails, prisons, and homeless shelters.[4]

In 2015, the best available data indicate that three times more people with serious mental illness are in jail or prison than are in primarily psychiatric institutions.[5] Among approximately two million incarcerated people in the United States, fifty percent or more have mental illness.[6] Not only are America’s jails and prisons the primary institutions for serious mental illness; managing serious mental illness ranks among the main functions of our jails and prisons.

The best estimates indicate, moreover, that eighty thousand people are currently held in isolation of some form in America’s prisons.[7] Up to half of these people are seriously mentally ill; the rates of serious mental illness in solitary are estimated to be twice as high as those in the general prison population.[8] While less than ten percent of a given state’s prison population is held in solitary confinement at a given time, as many as fifty percent of suicides occur in solitary.[9] Tabulation of suicides, moreover, is based on deaths, not attempts; even gravely self-injurious behavior with suicidal intent operates mostly as a disciplinary variable, not a medical one.[10]

Solitary confinement clearly causes or exacerbates symptoms of serious mental illness, including depression, psychosis, and self-directed violence.[11] However, the point that is often lost, and which bears clearer acknowledgement in contemporary empirical studies such as the one Glowa-Kollisch and colleagues conducted in New York, is the historical inextricability of solitary confinement and mental illness in the United States.[12] Solitary confinement developed alongside expanding incarceration of mentally ill people in the 1980s and 1990s; remains a tool of choice for managing mentally ill prisoners; and cyclically justifies itself as the violent behaviors it induces ostensibly demonstrate the ongoing need for extremely restrictive confinement.[13]

When Glowa-Kollisch and colleagues write that mental health services have been employed by correctional institutions “expressly to maintain the practice of solitary confinement,” they might therefore refer not only to the role of mental health professionals in approving inmates for solitary, but also to these cycles of positive feedback for institutional practice, wherein the very presence of seriously mentally ill people in jail or prison has become a primary justification for solitary confinement, which, in turn, induces or exacerbates mental illness.

This point bears directly on the second major issue we wish to raise: the ethical complexity of provider participation or abstention in fundamentally disciplinary practices, such as approving inmates for solitary confinement, in institutions with inherently limited transparency or accountability.

Few readers of these pages would dispute the premise that use of medical credentials to facilitate patently detrimental disciplinary practices, such as solitary confinement, is ethically aberrant. Indeed, the Physicians for Human Rights (PHR) report on dual loyalty cited by Glowa-Kollisch and colleagues clearly says as much, calling for health professionals to take “appropriate steps to avoid...misuse” of their training. Moreover, the PHR report states that “the health professional should not perform medical duties or engage in medical interventions for security purposes.”[14]

These are premises consistent with the ethical pillar of non-maleficence, with which few scholars of human rights or medical ethics would take exception. Glowa-Kollisch and colleagues aptly target this matter, referring to the “[quality improvement] priority” of “elimination of the CHS role in clearing patients for solitary confinement.” This agenda offers reasonable ethical face value. As the authors acknowledge, not only do ethical guidelines such as those developed by PHR remind providers to avoid harming patients in the name of disciplinary prerogative, but “the clearance process [for solitary confinement is] unsupported by scientific evidence and harmful to the patient/ provider alliance.”[15]

Ethical ambiguity arises, however, from the fact that the institutional setting is relatively closed, not open. As the PHR report on dual loyalty observes, “closed institutions, such as jails, prisons, psychiatric facilities and the military, impose high demands for allegiance on health professionals even in the face of often-common human rights violations against individuals held there.”[16] Indeed. The difficulty, however, is whether clinician abstention enables closed institutions to remain so.

Telling contrasts emerge from comparison of solitary confinement and the death penalty in the United States, wherein clinician abstention has facilitated transparency and introduced meaningful checkpoints. Clinician refusal to participate in executions, most recently in lethal injection protocols, has both made executions significantly more difficult to perform and inspired a more public conversation about the ethics of carrying out a punishment in which physicians

will not participate.

The legal differences between the imposition of the death penalty and the use of solitary confinement, however, render abstention potentially more ethically meaningful in the former context. A prisoner sentenced to death has an automatic right to appeal his sentence, including challenging the manner in which the sentence will be carried out. In most states, death-sentenced prisoners have a right to a lawyer throughout the appeals process. These procedural protections and judicial oversight imbue the execution process with legal transparency, in theory if not in practice.

No comparable protections or mechanisms of judicial oversight exist for prisoners in solitary confinement. Placement in solitary confinement is an administrative process, carried out by jail or prison officials; people in solitary have none of the procedural protections, such as the right to a lawyer or to an adversarial hearing, that criminal defendants have in death penalty proceedings. And anyone who wants to appeal his placement in solitary confinement has no guarantee that a judge will ever see, let alone evaluate, a claim of cruel and unusual punishment.

The legal differences between a sentence of death and an administrative assignment to solitary confinement have clear implications for clinical abstention. Whereas, in the death penalty context, clinical abstention is easily noticed and prone to review in a court of law, clinical abstention in the context of solitary confinement could well go unnoticed and unreviewed.

The authors' focus on dual loyalty remains, duly and reasonably, at the clinical level: if a clinician is asked to behave in a manner that is directly harmful to her patient, she is, after all, obligated to refuse. Those of us with the ethical luxury of clinical distance, however, might ask more trenchant questions: will clinicians' refusal to clear inmate-patients for solitary confinement simply remove a mechanism for diverting the most ill of their patients from the anguish of solitary? As provider abstention tallies a point for clinical ethics by avoiding immediate harm, does such abstention simultaneously strike against transparency and accountability, by allowing administrative discretion to exert itself with ever less scrutiny? And finally, the subtext that whispers from between the lines of the article: can a penal institution, managed on correctional prerogative, serve an ethically viable therapeutic function, in the first place?

Thomas R. Blair

Keramet A. Reiter

Thomas R. Blair, M.D., M.S., is Resident Physician in Psychiatry, Department of Psychiatry and Semel Institute for Neuroscience and Human Behavior, University of California, Los Angeles, California, USA.

Keramet A. Reiter, J.D., Ph.D., is Assistant Professor of Criminology, Law & Society and Law, Department of Criminology, Law and Society and School of Law, University of California, Irvine, California, USA.

Please address correspondence to the authors c/o Thomas Blair, Department of Psychiatry, 760 Westwood Plaza C8-193, Los Angeles CA 90024, email: trblair@mednet.ucla.edu.

Competing interests: None declared.

References

[1] S. Glowa-Kollisch, J. Graves, N. Dickey, et al. Data-driven human rights: using dual loyalty trainings to promote the care of vulnerable patients in jail. *Health and Human Rights Journal* 17/1 (2015), in press.

- [2] K. Reiter and T. Blair. "Punishing mental illness: trans-institutionalization and solitary confinement in the United States." In K. Reiter and A. Koenig (eds), *Extreme punishment: Comparative studies in detention, incarceration and solitary confinement*. New York: Palgrave MacMillan, 2015, in press.
- [3] G. N. Grob. "The Forging of Mental Health Policy in America: World War II to New Frontier." *The Journal of the History of Medicine and Allied Sciences*, 42 (1987), pp. 410-46.
- [4] J. Gilligan, "The last mental hospital," *Psychiatric Quarterly*, 72/1 (2001), pp. 45-61.
- [5] E. F. Torrey, A. D. Kennard, D. Eslinger et al., "More mentally ill persons are in jails and prisons than hospitals: a survey of the states," Treatment Advocacy Center & National Sheriff's Association (2010). Available at http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.
- [6] D. J. James and L. E. Glaze, "Mental health problems of prison and jail inmates," U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics (2006). Available at <http://www.bjs.gov/content/pub/pdf/mhppji.pdf>.
- [7] J. J. Gibbons and N. D. Katzenbach, "Confronting confinement: a report of the Commission on Safety and Abuse in America's prisons," *Washington University Journal of Law and Policy*, 22 (2006), pp. 385-562.
- [8] Correctional Association of New York, *States that provide mental health alternatives to solitary confinement* (2008). Available at http://www.correctionalassociation.org/wpcontent/uploads/2012/05/Out_of_State_Models.pdf.
- [9] T. Kupers, "What to do with the survivors? Coping with the long term effects of isolated confinement," *Criminal Justice and Behavior*, 35/8 (2008), pp. 1005-16.
- [10] Reiter and Blair (see note 2).
- [11] S. Grassian, "Psychiatric effects of solitary confinement," *Washington Journal of Law & Social Policy* 22 (2006), pp. 325–383. See also C. Haney and M. Lynch, "Regulating prisons of the future: a psychological analysis of supermax and solitary confinement," *New York University Review of Law and Social Change*, 23/4 (1997), pp. 477–570.
- [12] Reiter and Blair (see note 2).
- [13] Correctional Association of New York (see note 8).
- [14] Physicians for Human Rights, "Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines and Institutional Mechanisms" (March 2003). Available at <http://physiciansforhumanrights.org/library/reports/dual-loyalty-and-human-rights-2003.html>.
- [15] Glowa-Kollisch et al. (see note 1).
- [16] Physicians for Human Rights (see note 14).

Author Response

Sarah Glowa-Kollisch

Jasmine Graves

Nathaniel Dickey

Ross MacDonald

Zachary Rosner

Anthony Waters

Homer Venters

Blair and Reiter note the crucial issue of de-institutionalization and the migration of mentally ill patients into jails and prisons. For perspective, most persons in solitary confinement in the

United States are not seriously mentally ill (SMI) and these patients are increasingly excluded from this practice. Modern reliance on solitary confinement in the US started with the death of two correction officers in Marion State Penitentiary in 1983. There, the warden instituted a facility-wide lock down, and this approach gave rise to entire institutions dedicated to solitary confinement. Although the shift of patients from inpatient to correctional settings is clearly a contributor to solitary confinement, choices about confinement practices for non-SMI patients drive the bulk of the institution today.

Blair and Reiter draw an important comparison between health staff involvement in the death penalty and solitary confinement. While the goal of removing health staff from the punishment apparatus is clear, the path towards that end is complicated and dependent on the buy-in of security staff around alternative approaches. The recent exclusions of adolescent and SMI patients from consideration for solitary confinement has shrunk the footprint of solitary confinement in NYC and elsewhere, as have measures to limit the amount of time others can spend in these settings. As increasing numbers of patients are directed into treatment and therapeutic settings (both within jails and before incarceration), the scope of dual loyalty concerns for staff decreases and we gain credibility with security staff who are necessarily vigilant about their security mission.

| | |
|---------------|----------------|
| Sarah | Glowa-Kollisch |
| Jasmine | Graves |
| Nathaniel | Dickey |
| Ross | MacDonald |
| Zachary | Rosner |
| Anthony | Waters |
| Homer Venters | |

Sarah Glowa-Kollisch, MPH, is the Director of Policy and Evaluation in the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Jasmine Graves, MPH, is the Special Assistant to the Commissioner of Health at the New York City Department of Health and Mental Hygiene.

Nathaniel Dickey, MA, MPH, is the Special Assistant to the Assistant Commissioner of Correctional Health Services, Bureau of Correctional Health Services, New York City Department of Health and Mental Hygiene.

Ross MacDonald, MD, is the Medical Director of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Zachary Rosner, MD, is the Deputy Medical Director of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Anthony Waters, PsyD, is the Director of Mental Health of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Homer Venters, MD, MS, is the Assistant Commissioner of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Please address correspondence to: c/o Homer Venters, 42-09 28th St, 10th floor, Queens, NY, 11101-4132. Email: hventer1@health.nyc.gov.