Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics

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In recent years, prison officials have increasingly turned to solitary confinement as a way to manage difficult or dangerous prisoners. Many of the prisoners subjected to isolation, which can extend for years, have serious mental illness, and the conditions of solitary confinement can exacerbate their symptoms or provoke recurrence. Prison rules for isolated prisoners, however, greatly restrict the nature and quantity of mental health services that they can receive. In this article, we describe the use of isolation (called segregation by prison officials) to confine prisoners with serious mental illness, the psychological consequences of such confinement, and the response of U.S. courts and human rights experts. We then address the challenges and human rights responsibilities of physicians confronting this prison practice. We conclude by urging professional organizations to adopt formal positions against the prolonged isolation of prisoners with serious mental illness.

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Physicians who work in U.S. prison facilities face ethically difficult challenges arising from substandard working conditions, dual loyalties to patients and employers, and the tension between reasonable medical practices and the prison rules and culture. In recent years, physicians have increasingly confronted a new challenge: the prolonged solitary confinement of prisoners with serious mental illness, a corrections practice that has become prevalent despite the psychological harm it can cause. There has been scant professional or academic attention to the unique ethics-related quandary of physicians and other healthcare professionals when prisons isolate inmates with mental illness. We hope to begin to fill this gap.

Solitary confinement is recognized as difficult to withstand; indeed, psychological stressors such as isolation can be as clinically distressing as physical torture.[1,2] Nevertheless, U.S. prison officials have increasingly embraced a variant of solitary confinement to punish and control difficult or dangerous prisoners. Whether in the so-called supermax prisons that have proliferated over the past two decades or in segregation (i.e., locked-down housing) units within regular prisons, tens of thousands of prisoners spend years locked up 23 to 24 hours a day in small cells that frequently have solid steel doors. They live with extensive surveillance and security controls, the absence of ordinary social interaction, abnormal environmental stimuli, often only three to five hours a week of recreation alone in caged enclosures, and little, if any, educational, vocational, or other purposeful activities (i.e., programs). They are handcuffed and frequently shackled every time they leave their cells.[3–5] The terms segregation, solitary confinement, and isolation will be used interchangeably to describe these conditions of confinement.

Isolation can be psychologically harmful to any prisoner, with the nature and severity of the impact depending on the individual, the duration, and particular conditions (e.g., access to natural light, books, or radio). Psychological effects can include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis.[6]

The adverse effects of solitary confinement are especially significant for persons with serious mental illness, commonly defined as a major mental disorder (e.g., schizophrenia, bipolar disorder, major depressive disorder) that is usually characterized by psy-

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chotic symptoms and/or significant functional impairments. The stress, lack of meaningful social contact, and unstructured days can exacerbate symptoms of illness or provoke recurrence.[7] Suicides occur disproportionately more often in segregation units than elsewhere in prison.[8–10] All too frequently, mentally ill prisoners decompensate in isolation, requiring crisis care or psychiatric hospitalization. Many simply will not get better as long as they are isolated.

Mental health professionals are often unable to mitigate fully the harm associated with isolation. Mental health services in segregation units are typically limited to psychotropic medication, a health care clinician stopping at the cell front to ask how the prisoner is doing (i.e., mental health rounds), and occasional meetings in private with a clinician.[7] Individual therapy; group therapy; structured educational, recreational, or life-skill-enhancing activities; and other therapeutic interventions are usually not available because of insufficient resources and rules requiring prisoners to remain in their cells.[11]

The use of segregation to confine the mentally ill has grown as the number and proportion of prisoners with mental illness have grown. Although designed and operated as places of punishment, prisons have nonetheless become *de facto* psychiatric facilities despite often lacking the needed mental health services.[7] Studies and clinical experience consistently indicate that 8 to 19 percent of prisoners have psychiatric disorders that result in significant functional disabilities, and another 15 to 20 percent require some form of psychiatric intervention during their incarceration.[12] Sixty percent of state correctional systems responding to a survey on inmate mental health reported that 15 percent or more of their inmate population had a diagnosed mental illness.[13]

Despite significant improvements in correctional mental health services, often related to litigation and development of standards and guidelines by the National Commission on Correctional Health Care (NCCHC), the American Psychiatric Association (APA), and other professional organizations, in many prisons the services remain woefully inadequate. Relative to the number of prisoners needing help, there is an insufficient number of qualified staff, too few specialized facilities, and few programs.[7] Mindful of budget constraints and scant public support for investments in the treatment (as opposed to punishment) of prisoners, elected officials have been reluctant to provide the funds and leadership needed to ensure that prisons have sufficient mental health resources. Twenty-two of 40 state correctional systems reported in a survey that they did not have an adequate mental health staff.[13]

Persons with mental illness are often impaired in their ability to handle the stresses of incarceration and to conform to a highly regimented routine. They may exhibit bizarre, annoying, or dangerous behavior and have higher rates of disciplinary infractions than other prisoners. Prison officials generally respond to them as they do to other prisoners who break the rules. When lesser sanctions do not curb the behavior, they isolate the prisoners in the segregation units, despite the likely negative mental health impact. Once in segregation, continued misconduct, often connected to mental illness, can keep the inmates there indefinitely.[7,14]

In class action cases challenging the segregation of inmates with serious mental illness as unconstitutionally cruel because of the psychological harm it can inflict, U.S. federal courts have either issued rulings or accepted settlements that prohibit or sharply curtail the practice. According to one federal judge, putting mentally ill prisoners in isolated confinement "is the mental equivalent of putting an asthmatic in a place with little air. . . ."[15] Unfortunately, except in the small number of prisons governed by the outcome of such litigation, mentally ill prisoners continue to be sent to segregation; indeed, they are often disproportionately represented in segregation units.[16,17]

International treaty bodies and human rights experts, including the Human Rights Committee,[18] the Committee against Torture,[19,20] and the U.N. Special Rapporteur on Torture,[21] have concluded that solitary confinement may amount to cruel, inhuman, or degrading treatment in violation of the International Covenant on Civil and Political Rights[22] and the Convention against Torture and other Cruel, Inhuman, and Degrading Treatment or Punishment.[23] They have specifically criticized supermax confinement in the United States because of the mental suffering it inflicts.[19,20] Whatever one's views on supermax confinement in general, human rights experts agree that its use for inmates with serious mental illness violates their human rights.

Principles of ethics regarding beneficence, nonmaleficence, and respect for the rights and dignity of all patients have led international and national profes-

sional organizations to affirm that physicians are ethically obligated to refrain from countenancing, condoning, participating in, or facilitating torture or other forms of cruel, inhuman, or degrading treatment.[24–27] Involvement of healthcare practitioners in abusive interrogations recently prompted the American Medical Association[28] and the APA[29] to oppose the participation of physicians in interrogations. Two years ago, the NCCHC issued a position statement that correctional health care professionals "should not condone or participate in cruel, inhumane or degrading treatment of inmates."[30] To date, however, the medical organizations have not formally acknowledged that prolonged isolation of the mentally ill constitutes cruel or inhuman treatment in violation of human rights, nor have they addressed health professionals' ethics-related responsibilities when faced with such cases.

Correctional health care professionals struggle with constrained resources and large caseloads that limit the services they can provide their patients. It is ethical for them to do the best they can under the circumstances rather than resigning, which would result in even fewer services for their patients. But what are practitioners' ethics-related responsibilities when prison officials impose conditions of confinement that exacerbate the symptoms of a prisoner's mental illness?

The ethic-based calculus physicians face when prisoners are isolated for disciplinary or security reasons is different than that created by the struggle with limited resources. Segregation of mentally ill prisoners (or any other prisoner) is not an unintended consequence of tight budgets, for example. It reflects a penal philosophy and the conscious decision by prison officials about whom to isolate, for how long, and under what conditions. 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? What must they do to avoid being complicit in conditions of confinement that may well constitute a human rights violation?

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.[31–33]

Publically exposing and urging change in harmful prison practices is difficult and, needless to say, can threaten job security, but individual practitioners should not have to wrestle alone with a prison practice that violates human rights norms. Their professional organizations should help them. Through the organizations, health professionals collectively can support colleagues who work in prisons in the quest to ensure ethically defensible correctional policies. The APA[34] and the NCCHC[35] have provided basic frameworks for increased mental health monitoring and treatment of segregated inmates. They must do more, however.

Professional healthcare organizations should acknowledge that prolonged segregation of inmates with serious mental illness violates basic tenets of mental health treatment. The mental health standards of the NCCHC include the "optional recommendation" that mentally ill prisoners be excluded from extreme isolation,[35] noting in an appendix that clinicians "generally agree that placement of inmates with serious mental illnesses in settings with 'extreme isolation' is contraindicated because many of these inmates' psychiatric conditions will clinically deteriorate or not improve (Working Group on Schizophrenia, 1997)."[36,37] In light of that general consensus, shouldn't the NCCHC make the exclusion mandatory, instead of optional? The APA and AMA should also formally adopt a similar position.

However, adopting a similar position is easier said than done. Very few physicians in the APA and AMA have experience or knowledge regarding correctional mental health care, let alone correctional environments in general. They are not familiar with the differences between a general population housing unit and a disciplinary segregation housing unit. Administrative segregation, supermax, rules infractions, mental health rounds, and "kites" are terms most noncorrectional physicians do not understand. In short, we recognize that a serious educational effort must be mounted so that noncorrectional mental health practitioners have a better understanding of the world in which their correctional colleagues work and the unique challenges they face, including the isolation of seriously ill patients for months, even years, that would never be condoned in a noncorrectional mental health setting.

No doubt some correctional mental health clinicians will not agree with us. They may believe the isolation of volatile mentally ill prisoners is necessary

for security reasons. They may believe they are guests in the house of corrections who have no business addressing custody policies, or they may have become so accustomed to the extended use of isolation that they have lost sight of its potential to cause psychological harm.

Experience demonstrates that prisons can operate safely and securely without putting inmates with mental illness in typical conditions of segregation. Because of litigation, in some prisons, mentally ill prisoners who would otherwise be locked in their cell for 23 to 24 hours a day are given more time outside their cells, including time in group therapy and other therapeutic interventions.[11] The improved clinical responses of prisoners with mental illness have been achieved without sacrificing needed controls or relinquishing the goal of holding those accountable, whether mentally ill or not, who willfully violate prison rules.

The professional organizations should acknowledge that it is not ethically defensible for health care professionals to acquiesce silently to conditions of confinement that inflict mental harm and violate human rights. They should affirm that practitioners are ethically obligated, not only to treat segregated inmates with mental illness, but also to strive to change harmful segregation policies and practices.[31–33] Finally, the organizations should not be content with clarifying the ethics-related responsibilities of individual practitioners in these circumstances. They should actively support practitioners who work for changed segregation policies, and they should use their institutional authority to press for a nationwide rethinking of the use of isolation. The medical professions' commitment to ethics and human rights would be well served by such steps.

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