

MENTAL HEALTH CONSIDERATIONS FOR SEGREGATED INMATES

By Jeffrey L. Metzner, MD, CCHP-A

The scientific literature remains problematic, due to methodological issues, concerning the impact of locking an inmate in an isolated cell for an average of 23 hours per day with limited human interaction and minimal or no programming in an environment designed to exert maximum control over the individual (Gendreau & Labrecque, in press; Perrien & O'Keefe, 2015). However, mental health clinicians working in correctional facilities frequently report that it is not uncommon for inmates who have no preexisting serious mental disorders to develop irritability, anxiety, and other dysphoric symptoms when housed in segregation units for long periods of time (Metzner, 2002). Kaba and colleagues (2014) found self-harm to be associated significantly with being in solitary confinement at least once, serious mental illness, being aged 18 years or younger, and being Latino or White, regardless of gender.

Zinger and Wichmann (1999) provide a very useful literature review relevant to the psychological effects of 60 days in segregation. They point out that the literature in this area is conflicting, filled with speculations, and often based on far-fetched extrapolations and generalizations. Methodological shortcomings apparent from reviewing the literature include reliance on anecdotal evidence, response bias, nonexistent or poor comparison groups, wide variation regarding the conditions of confinement in different prisons, cross-sectional design in contrast to a longitudinal design study, and an overreliance on field and laboratory experiments pertinent to sensory deprivation (Gendreau & Labrecque, in press; Perrien & O'Keefe, 2015).

Zubek, Bayer, and Shephard (1969) conceptualized segregation units as having three main characteristics: social isolation, sensory deprivation, and confinement. Each of these elements can vary significantly, as will different inmates' responses to the segregation experience. In general, the decreased or altered social interactions appear to be more of a problem from a mental health perspective compared to sensory deprivation. In fact, many of the milieus in such units are characterized by sensory overstimulation (e.g., inmates yelling for communication purposes or for other reasons). Radios and television sets, which may be available in these housing units, can decrease or eliminate sensory deprivation, although the severe disruption in normal social interactions remains a problem (Metzner, 2002).

The difficulties of providing appropriate and adequate access to mental health care and treatment are especially problematic in a segregation environment. Logistical barriers frequently include inadequate office space and limited access to inmates because of security concerns. In correctional settings with inadequate mental health services, it usually is not difficult to find inmates with serious mental illnesses in segregation housing units because their untreated or inadequately treated mental illnesses often result in significant behavioral problems. Subsequent segregation placement often occurs due to the lack of available appropriate mental health housing and programming.

Gendreau and Labrecque (in press) describe the two dominant schools of thought regarding the impact of segregation housing on an inmate's mental health. One school equates the segregation environment with torture since it is perceived to be psychologically very harmful to inmates (Haney, 2012; Jackson, 1983). Another school's position is that segregation results in far fewer negative effects and only for some inmates in prisons that meet basic standards of humane care (Clements et al., 2007; Gendreau & Goggin, 2013).

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 (Work Group on Schizophrenia, 1997). In other words, many inmates with serious mental illnesses are harmed when placed in such settings. In addition to potential litigation, this is a main reason that an increasing number of the so-called supermax facilities will not admit inmates with serious mental illnesses.

Consistent with the above, the Society of Correctional Physicians adopted a position statement in July 2013 that stated the following:

The Society of Correctional Physicians acknowledges that prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment. Inmates who are seriously mentally ill should be either excluded from prolonged segregation status (i.e., beyond 4 weeks) or the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities and adequate time in an appropriately designed outdoor exercise area.

SCP further recommends that correctional systems provide mental health input into the disciplinary process in order to appropriately shunt some of these inmates into active mental health housing and programming rather than disciplinary segregation when the mental condition is a mitigating factor in the commission of the infraction.

The American Psychiatric Association (APA) developed a similar position statement in 2012.

There is a growing movement by health care staff and national organizations within the United States to exclude inmates from long-term segregation housing (New York Civil Liberties Union, 2012). These efforts at exclusion have been much more successful for inmates with serious mental illness. Improvement in the dismal conditions of confinement, however, should be extended to all inmates in segregation settings. This may require long-term advocacy and perseverance before such changes occur. Until then, the processes described below can at least minimize the harm caused by segregation housing units.

For many years, international treaty bodies and human rights experts, including the Human Rights Committee (United Nations Human Rights Committee, 1992, 2006), the Committee Against Torture (United Nations Committee against Torture, 2006), and the U.N. Special Rapporteur on Torture (Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2008), have concluded that solitary confinement may amount to cruel, inhuman, or degrading treatment in violation of the International Covenant on Civil and Political Rights (1976) and the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1987). Many correctional health care clinicians are unaware of these international views.

Recommendations

A mental health screening process, which should include screening assessments at the sending facility and the receiving facility with the segregation housing units, is a recommended mechanism to identify inmates with serious mental illnesses in a timely fashion. Inmates with serious mental illnesses and developmentally delayed inmates are usually excluded from admission to extreme isolation housing unless a specialized mental health program exists within the institution similar to residential treatment programs for general population inmates with serious mental illnesses (Haddad, 1999; Metzner, 1998; Metzner & Dvoskin, 2006).

Regardless of the admission policies relevant to inmates with serious mental illnesses, in a supermax facility, mental health staff should regularly perform rounds in all housing units as an additional mental health screening procedure. This screening is necessary as it is frequently not possible to predict an individual inmate's reaction to confinement in a segregation unit characterized by extreme isolation. Use of a mental health liaison consultation model with the correctional and health care staffs, along with the rounds process, will facilitate the timely identification of inmates exhibiting acute symptoms of mental illness and the provision of appropriate clinical interventions.

Similar rounds should be performed on a regular basis by health care staff, preferably mental health staff, in other segregation housing units as outlined in the National Commission on Correctional Health Care's *Standards for Mental Health Services in Correctional Facilities* (2015). The *Standards* specify the required monitoring based on the inmate's degree of isolation. If the monitoring is not provided by mental health staff, health care staff who do the monitoring should be trained on pertinent mental health issues.

While important for screening and triage, mental health rounds at the cell front do not substitute for clinically indicated assessment or treatment sessions. Such clinical interventions should occur out-of-cell in a safe setting that allows for adequate sound privacy.

A task force of the APA (2015) recommended that provision of essential mental health services in segregation housing should observe the following principles:

1. No inmate should be placed in segregation housing solely because he or she exhibits the symptoms of mental illness, unless there is an immediate and serious danger for which there is no other reasonable alternative. (This principle does not refer to medical or psychiatric seclusion, which should follow state mental health law and professional practice.)
2. Inmates with a serious mental illness who are a high suicide risk or have active psychotic symptoms should not be placed in segregation housing.
3. When an inmate is placed in segregated housing for appropriate correctional reasons, the facility remains responsible for meeting all of the serious medical and psychiatric needs of that inmate. Thus, such inmates must receive any mental health services that are deemed essential, their segregation status notwithstanding.
4. Inmates who are in severe psychiatric crisis, including but not limited to acute psychosis and suicidal depression, should be removed from segregation.
5. Inmates known to have serious mental health needs, especially those with a known history of serious and persistent mental illness, when housed in segregation must be assessed on at least a weekly basis by qualified mental health practitioners to identify and respond to emerging crises at the earliest possible moment.
6. Institutions should provide for regular rounds by a qualified mental health clinician in all segregation housing units. During these rounds, each inmate should be visited briefly so that any emerging problem can be assessed. The clinician should also communicate with segregation security staff to identify any inmate who appears to be showing signs of mental deterioration or psychological problems.
7. A policy and procedure should be developed and implemented relevant to the provision of mental health input into the disciplinary process with a focus on assessing potential mitigating factors that contributed to the inmate's alleged disciplinary infraction.
8. Alternatives to prolonged segregation for inmates should be developed by correctional systems.

Contribution

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