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What is This?
Guest Editorial

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Marc F. Stern, MD, MPH

I found solitary confinement the most forbidding aspect of prison life. There is no end and no beginning; there is only one’s mind, which can begin to play tricks. Was that a dream or did it really happen? One begins to question everything.


When Carly Simon sang “Nobody does it better” in 1977, she may have been describing the U.S. penal system . . . at least if you believe that more is better. The United States imprisons 716 of its citizens per 100,000, more than any other nation. We surpass Cuba (510), Russia (475), and even Iran (284; Walmsley, 2013). We are “good” at two other things, too. We are good at imprisoning citizens who are mentally ill. As a result of what is called deinstitutionalization—I prefer to call it transinstitutionalization—jails and prisons now house more mentally ill than do our mental institutions. We are also good at confining prisoners in our “jail within the jail,” isolation (also called segregation, restricted housing, or solitary confinement), estimated by the Bureau of Justice Statistics to be over 67,000 citizens in 2005 (E. Ann Carson, Bureau of Justice Statistics, personal communication, December 20, 2013. This estimate is limited to state and federal prisons; it does not include citizens in segregation in jails). The convergence of these three U.S. distinctions has resulted in an epidemic of seriously mentally ill (SMI) individuals housed in isolation (28% to 50% of all those in isolation, in some states; Abramsky & Fellner, 2003), experiencing sometimes no more than 3 to 5 hours per week out of their cell, little meaningful interaction with others, little educational or social programming, and sequestered there for periods that can last from days to years. Yes. Years.

There is strong evidence that placing individuals with SMI in isolation is not good for the individual’s health nor the welfare of the institution, if not also inhumane and unconstitutional.
(Grassian, 2006; Scharff-Smith, 2006; Shalev, 2008). In the words of one court, “[P]lacing them in [isolation] is the mental equivalent of putting an asthmatic in a place with little air to breath” (Madrid v. Gomez, 1995). A recent well-designed seminal study of the psychological effects of isolation in the Colorado Department of Corrections, while not proving all the authors’ hypotheses, certainly supported existing literature that placing SMI individuals in isolation does not make them healthier (O’Keefe et al., 2013).

As health care professionals, what should we do ... and what can we do? Metzner and Fellner called on professional organizations to help guide the way. Last July, the Society of Correctional Physicians (SCP) answered that call. In a short but powerful three-sentence position statement, noting that prolonged segregation of individuals with SMI violates basic tenets of mental health treatment, SCP called for isolation of those with SMI to be short (< 4 weeks) or modified to ensure adequate out-of-cell treatment and exercise (SCP, 2013). The statement also called for correctional systems to include mental health input in the disciplinary process to help shunt certain individuals from segregation into more therapeutic milieus. With this statement, SCP joins other responsible voices, including the United Nations General Assembly (1990) and the American Psychiatric Association (APA; 2012).

SCP’s call for involvement of health care professionals in the disciplinary process may generate some controversy. Some ethical authorities argue that health care professionals must distance themselves from involvement in the disciplinary process, lest they appear to their patients to have loyalty to other than only the patient (Raed Aburabi, coordinator of health care in detention, International Committee of the Red Cross, personal communication, June 24, 2013; United Nations General Assembly, 1982). However, even consultation with security authorities after the disciplinary process is complete for the purpose of recommending diversion from segregation can send a similar message (“Why didn’t you advocate for me and tell them I shouldn’t be here?”). Metzner (2002) offers a practical solution: Let the health care professional advising the disciplinary process be someone not involved in the patient’s care.

Heeding published evidence, court or federal oversight pressure, or the professional advice of organizations like APA and SCP, some states, such as Massachusetts, Pennsylvania, Colorado, and others, have begun changing the way they use isolation for individuals with SMI.

But unfortunately, the changes in these state systems, and SCP’s and others’ guidance on how to comport ourselves as health care professionals in the face of the social and health travesty that is SMI citizens locked in isolation, may divert our attention from the fact that the changes help fix a condition that should not exist. We are “good” at segregating individuals, but segregation is not a sine qua non of a safe, effective correctional system. A delegation from Pennsylvania, Colorado, and Georgia that recently visited prisons in Germany and the Netherlands discovered that segregation cells are rarely used. And yet the prisons are as safe, if not safer, than ours (Subramanian & Shames, 2013).

SCP’s position statement calling for improved care for individuals with SMI is laudable. Health care professionals should wave it from the hilltops. We should talk about it with our health care colleagues, our custody colleagues, and our government officials. But let us remember that the issues it addresses should be moot. As a society, we should be investing our efforts in treating and preventing mental illness and chemical dependency, efforts that the scientific evidence has proven—especially for the latter—will reduce costs, improve public safety, and improve public health. Until that day comes, the day when jails and prisons are smaller, only rarely imprisoning a citizen with SMI, and only rarely placing a citizen in isolation, SCP’s call to action is a critically important Band-Aid.

References