TARGETS, TREATMENTS, & ETHICS: PROVIDING CARE IN SOLITARY CONFINEMENT

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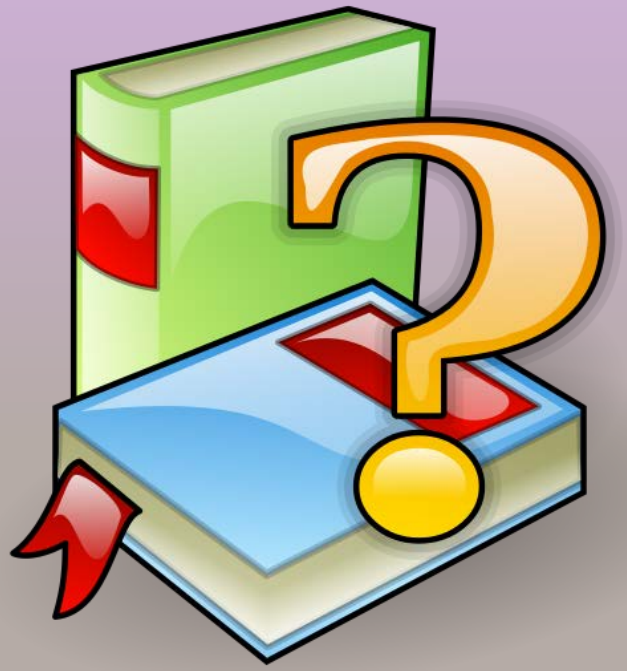
Synopsis of Presentation

- Overview of Solitary Confinement
- Targets for Intervention in Solitary Confinement
- Treatment Best Practices in Solitary Confinement
- Direct Practice Ethics in Solitary Confinement

OVERVIEW OF SOLITARY CONFINEMENT

Definitions

- Solitary confinement is defined as restricting a person to a cell for a minimum of 22 hours out of a 24 hour period.
- Solitary confinement goes by many names in the US
  - With very few exceptions, they all mean the same thing!
- Supermax versus other prison types
- Short term versus prolonged (or extended)
- Determinate versus indeterminate/indefinite time



(Government Accountability Office, 2013)

US Solitary Confinement Statistics

- There is a wall of secrecy around the use of solitary confinement in the US.
- 80,000-100,000 people in the US adult prison/jail system are held in solitary confinement every day.
- Approximately 13% of the prison/jail population (or 260,000) report having spent time in prolonged solitary confinement within the last year.
- The mentally ill, people of color, and those who identify as LGBTQ are disproportionately placed in solitary confinement and remain there for longer periods of time.
- Thousands of people have been held in solitary confinement for decades.
- Over 50% of all suicides in prisons and jails occur within solitary confinement.
- There is no evidence that the use of solitary confinement makes prisons safer.

(Beck, 2015; Browne, Cambier, & Agha, 2011; Cloud, Drucker, Browne, & Parsons, 2015; Department of Justice, 2016; Houser & Belenko, 2015; Kaba et al., 2014; McGinnis et al., 2014)

TARGETS FOR INTERVENTION IN SOLITARY CONFINEMENT

Severe Psychiatric Conditions & Solitary Confinement Effects

- Severe mental Illness and active psychosis
  - Disproportionate percentage of mentally ill, especially severely mentally ill.
  - Schizophreniform, Schizophrenia, Schizoaffective Disorders
  - Brief Psychotic and Delusional Disorders
  - Bipolar I & II Disorders, and Major Depressive Disorder
  - Complex PTSD
  - Suicidality & Self-Injurious Behaviors
- The effects of solitary confinement
  - The SHU Syndrome
  - Those with and without a history of mental illness are at risk.
  - Those with a severe mental illness are more vulnerable.
  - The longer the stay, the more likely they are to develop these symptoms.
  - It is unknown how these symptoms dissipate upon release, or if they even do.

(Ahalt et al., 2017; Beck, 2015; Cloud, Drucker, Browne, & Parsons, 2015; Grassian, 2006; Haney, 2003; Morgan et al., 2012)

Sensory Stimulation

- Over-stimulation
  - Lights – Bright florescent lights 24/7/365
  - Sounds – Banging, yelling, doors closing/opening, walking, keys jingling
  - Temperature – too hot or too cold
  - Sleep deprivation – All of above + 30 minute checks with flashlight in face
- Under-stimulation
  - Human touch – No human touch other than incidental during cuffing
  - Same smells, sounds, sights, tastes 24/7/365
  - Normal conversation – either can't see or can't hear the person, sign language and exaggerated wording
- Hypersensitivity to sensory stimuli

Time, Boredom, Hope, Empowerment, & Culture

- Time & Boredom
  - Length of time
  - Passage of time
  - Entertainment/Distraction
  - Goal-directed activity

(Winters, 2018)

- Hope & Empowerment
  - Basic needs
  - Existential Issues
  - System fairness/trust
  - Seeing a path out
  - Family and social support
  - Personal efficacy

- Prison Culture
  - Importation Theory
  - Deprivation Theory
  - Decision-making
- Institutional Culture
  - Punitive v. Restorative
  - System consistency
  - Interaction/Humanity

TREATMENT BEST PRACTICES IN SOLITARY CONFINEMENT

Engagement and Stabilization

- Engagement
  - Distrust of mental health providers is common.
  - Engagement approaches best suited are strengths-based and relational.
  - Limits to confidentiality
  - Cultural competency
- Stabilization
  - Multiple functional impairments
  - Psychopharmacological treatment is standard.
  - Involuntary medication may be necessary to achieve stabilization.
  - Some reality testing may be successful as they start to clear up.

Therapeutic Work

- Intervention
  - The primary goals = surviving solitary and getting off ASAP.
  - Therapeutic work should take place in a confidential area.
  - Culturally-appropriate applications of behaviorally-based sides of:
    - Dialectical Behavioral Therapy
    - Acceptance and Commitment Therapy
    - Mindfulness-Based Stress Reduction
    - Solution-Focused Therapy
  - Limit deeper cognitive or interpersonal processing.
  - Avoid “normalizing” the environment.
- Evaluation
  - Psychiatric stability
  - Management of the symptoms related to solitary confinement effects
  - Behavior in relation to stated personal needs, goals, and values

(Winters, 2018)

Advocacy

- On the Inside
  - There are no whistle-blower protections for those who choose to speak out
  - Provide mental health services at a high frequency and intensity
  - Position mental health services as an influence in the review process
  - Educate others on the dangers of solitary confinement and about safe alternatives
  - Work toward improving basic conditions and grievance procedures
  - Promote a step-down process that allows for early release from solitary
  - Create trauma-informed care training for correctional staff on solitary units
- On the Outside
  - Collaborate with other advocates and organizations
  - Work with state and federal legislators
  - Create partnerships with local or state institutions
  - Talk about it. Educate others.

(Winters, 2018)

DIRECT PRACTICE ETHICS IN SOLITARY CONFINEMENT

Dual Loyalty & Cultural Competency

- Dual Loyalty
  - Provide care versus participate in torture
  - Standard limits to confidentiality versus agency limits to confidentiality
  - Therapy “at the door”
  - Client self-determination in an environment that does not value freedom
- Cultural Competency
  - Traditional cultural competency
  - Prison & institutional culture
  - System disparity

(Winters, 2018)

Evaluations, Reviews, & Disciplinary Boards

- Role and Central Driving Force
  - Role = “Mental Health Advocate”
  - Central Diving Force = “Client Well Being”
- Participating in Evaluations
  - Mental fitness for solitary confinement
  - Suicidal/homicidal thoughts or self-injurious behaviors
- Participating in the Review Process
  - Primary patient goals = survive solitary and get off solitary
  - Provide context to behavioral issues and highlight progress
- Participating in Disciplinary Boards
  - Offering safe alternatives to solitary confinement
  - Promoting the least restrictive environment
  - Educating about the dangers of solitary confinement

(Winters, 2018)

Competence and Self-Care

- Competence
  - Evidence-based practice
  - Understanding the symptoms of SHU syndrome
  - The role of ACEs
  - The influence of culture
  - Broad range of offerings
- Self-Care
  - Use of supervision
  - Regular self-care activities
  - Joining with “like minds”
  - Awareness of secondary traumatic stress and compassion fatigue
  - Advocacy
  - Knowing when it is time to leave

Research

- More empirical evidence of the SHU Syndrome, especially related to degrees of severity
- A better understanding of why some develop these symptoms while others do not and why some suffer from such severe symptoms while others might only have mild symptoms
- Stress levels before, during, and after solitary confinement
- A better understanding of how SHU Syndrome symptoms dissipate (if they do)
- A stronger evidence base for treatment

ANY QUESTIONS?

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