Penal Isolation: Thoughts on Basic Change

by Fred Cohen

Reform of solitary confinement, by whatever name it may have, is in the air. The American Bar Association Standards for Criminal Justice, Treatment of Prisoners, Standard 23-2.7.8.9 provides a sensible, low-grade approach to reform. By “low-grade” I do not mean low quality, particularly since I helped draft the Standards I mention.

The Association of State Correctional Administrators, Resolution #24 contains a 13-point program for reform that contains no outside durational limits but in calling for periodic review every 180 days tacitly accepts extended terms.

There are no clear rules on the conditions of confinement but program opportunities are to be provided. This is, no doubt, a small step forward—but just that.

The Federal Bureau of Prisons is engaged in a systemwide study of its use of penal isolation with some hope for ending its extraordinary terms of isolation at Administrative Maximum Facility (ADX) Florence.

Massachusetts, New York, Mississippi, Michigan, and Maine have undergone some modernizing of the use of extended penal isolation. Arizona is in the midst of litigation that challenges its misuse of penal isolation.

Study after study, position paper after position paper stakes out a claim concerning solitary confinement. An American Civil Liberties

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Basic Components of a Correctional Mental Health System

by Fred Cohen

If ever there was an idea whose time has come it is reform of correctional mental health care systems. The reform, as readers of this publication certainly know, is litigation-driven with legal advocates finding shocking deficiencies in care and federal court judges signing off on settlements and oversight via independent monitoring.

Arizona is under fire, South Carolina reeling from a successful lawsuit, California trying to repackage its mental health care in the wake of Brown v. Plata, 131 S.Ct. 1910, (2011), which ordered prison population reduction as a precursor to improving medical and mental health care.

This taste for reform is rooted in the Eighth Amendment’s proscription of Cruel and Unusual Punishment. The conceptual and linguistic difficulties here are profound. At bottom, the problem is to extract a positive right to a given level of mental health care from a negative injunction. Finding a right to minimally adequate health care in the interstices of “do no harm” along with the qualifying requirement of a “serious disorder” is difficult.

Add to the mix, the mind-bending legal construct of “deliberate indifference” and the seeds of pervasive debate are sown. Deliberate indifference is the behavioral/mental standard by which to measure the constitutional acceptability of a challenged health care system (or, indeed, an individual claim for damages for poor care in a federal action).

To provide some assistance to those seeking to evaluate the level of constitutional compliance in a facility or correctional system, I will first provide the well known six components derived from Ruiz v.

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Estelle, 503 F.Supp. 1265 (S.D. Tex. 1980). While courts continue to use those criteria, I found them dated and inadequate. Thus, I created 16 factors (or criteria) and, in so doing, distinguish the “required” from the “desired.”

Finally, I will provide the 10 factors put forward by Dr. Terry Kupers, a psychiatrist with a profound commitment to this work and who has changed many lives for the better with his work.

Minimal Components: Ruiz

It is difficult, although not impossible, to predict what may be constitutionally acceptable for inmate mental health care, diagnosis, and recordkeeping. Six legally acceptable components, as articulated first in Ruiz involving the Texas Department of Corrections, provide a very useful initial guide to a solution:

1. First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment;
2. Second, treatment must entail more than segregation and close supervision of the inmate patients;
3. Third, treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders;
4. Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained;
5. Fifth, prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluations, is an unacceptable method of treatment;
6. Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program.

Cohen

It is useful to compare this guide to what may be minimally acceptable with a set of 16 factors I prepared that can be described as ideal, or at least comprehensive:

1. Diversion of selected offenders with mental illness. There is a virtual unanimity in the literature, and among experts, that too many prisoners with serious mental illness are swept into jail and prison and often for minor offenses. A progressive system would provide legal authorization for pre-trial examinations and diversion to treatment where appropriate. 2

Identification of inmates with mental illness entering the system. Unless the system has in place mechanisms to identify those needing care, either at reception or after confinement, it simply cannot meet its treatment obligations. Better systems will have a computerized classification and tracking system.

Identification for appropriate care of inmates suffering from alcoholism, drug addiction, sexual dysfunction, or problems associated with the “battered woman syndrome.” These conditions generally fall outside of legally mandated care. However, a correctional system that is a “full service” system is responsive to these impaired individuals, and that in itself is deemed desirable. Compliance with basic legal requirements, as noted, would encompass only the seriously mentally ill. However, a comprehensive system would have a fully integrated system and not draw artificial distinctions between “special needs” categories.

Training of staff on the signs and symptoms of mental disorder and inmates with “special needs.” The identification of those who need care does not end at the front door, nor is it limited to mental health specialists.

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rate of suicide among prisoners subjected to solitary confinement than that among the general prison population.


4. See for example, Istanbul Statement on the use and effects of solitary confinement, Adopted on 9 December 2007 at the International Psychological Trauma Symposium, Istanbul (Istanbul Statement on the use and effects of solitary confinement); Interim Report by the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 5 August 2011, United Nations General Assembly A/66/268, para 46.


6. Babar Ahmad and Others v. UK, ECHR Judgment, 10 April 2012, para.90 (citing information from Dr Paul Zohn, psychologist assigned to ADX).


8. Jose Wilson, “Loneliness Is a Destroyer of Humanity,” article written by an inmate who has spent 12 years in isolation at ADX. Published by Sul Rodriguez as part of the ‘Voices from Solitary’ series on the ‘Solitary Watch’ website http://solitarywatch.com/2012/07/07/voices-from-solitary-loneliness-is-destroyer-of-humanity/.

9. Cunningham v. BOP.
11. Cunningham v. BOP p. 22.

12. According to the Cunningham v. BOP lawsuit he had spent time in protective custody after testifying against three inmates he had witnessed murder another prisoner; he reportedly escaped from a medium security prison after learning that he was to be placed back in the prison’s general population.

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Security staff, especially those assigned to mental health special care units and to segregation units, must be able to identify those who need care and understand the behavior associated with the condition or any medications involved. Such training should be subjected to rigorous evaluation of the information conveyed, attitudes changed, and behavior changed.

5. Adequate (in quantity and quality) human resources available for the various tasks associated with mental health treatment. Mental health staff should be appropriately licensed, multi-disciplined, and function administratively in an integrated fashion. Staffing ratios for psychiatrists, psychologists, social workers, and others should be established at least as a rough guide for judging the objective quality of a system. Opportunities will exist for staff development and enrichment. “Burn out” and “dry out” seem endemic to staff members in this highly charged work area, and comprehensive programs will provide opportunities for growth and respite.

6. Adequate (in quantity and quality) physical resources available. Obviously, a certain amount of physical space designed for various treatment or program objectives must be made available. The available space should be designed to meet the needs for hospitalization, long-term care that does not require hospitalization, crisis care (e.g., suicide-watch placements), transitional care, and perhaps special needs (e.g., housing the dual-diagnosed inmate). A “least restrictive environment” approach suggests enhanced concern for the inmates’ needs.

7. Access to care. Without ready access to diagnosis and care, human and physical resources become virtually meaningless. This calls for a study of waiting lists, response to “kites,” knowledge by security staff and inmates on how to gain access, appropriate training, and instruction to inmates regarding how to gain access. From the standpoint of actually auditing a system, access must be evaluated on site. Cells, beds, and staff may be counted, but access is a dynamic concept and must be observed. A model system would perform regular audits, question inmates and staff, assess the orientation process, and even do emergency “trial runs.” In evaluating access to care, one necessarily also evaluates the relationship between security and mental health staff. Without a collaborative approach, no system will function very well.

8. Contents of records. Records are crucial to the legal requirement of continuity of care. They are evidence of the care and are instrumental in assuring its quality. As a barometer of quality, the use of regular progress notes and a comprehensible individual treatment plan will show whether appropriate care is given and will make the personnel changes that are endemic to corrections less disruptive of the care process. The legal concern here is with continuity of care. The mental health record is a necessary, although not sufficient, factor in meeting that obligation.

9. Medication management. Without necessarily endorsing the practice, we must recognize that medication is the treatment of choice for the mentally ill inmate. This means that there should be reasonable access to the psychiatrist, a formulary that allows access to the newer psychopharmacological agents that are emerging at a rapid pace, and regular monitoring and testing. In systems with rapid turnover, or that use locum tenens psychiatrists, special attention must be paid to medication practices, especially changes in medication.

10. Restorative opportunities. For the seriously mentally ill medication may well be the treatment of choice, but it should not be the only treatment or programming available. For those not taking medication it is even more important to have a full range of activities, along with individual and group therapy. Comprehensive programs offer work opportunities along with structured physical activities, horticultural programs, guide-dog training, vocational training, and the like. Programs dealing with anger
management, social skills development, educational opportunities and the like often enhance restorative opportunities.

11. Management information system (MIS). A model MIS should be computerized and used for needs assessment, quality assurance (CQI), and tracking. Model programs will produce concrete examples of how MIS is used in the system.

12. Quality Assurance program. An ongoing internal survey, evaluation, and feedback system accompanied by a statutory, evidentiary privilege to safeguard such studies from disruptive discovery demands should be part of any sophisticated system.³

13. Data/research on treatment outcomes. Comprehensive programs will not be content to simply “build, hire, and provide access.” They will be concerned with the articulation of treatment objectives and will be engaged in acceptable research on outcomes. Articles in peer reviewed publications would provide extremely good evidence on this point.

14. Economy of scale. The administrative and organizational structures should be designed to provide the maximum care for the funds allocated. Are services regionalized (or clustered)? Are services shared and accessible? Are actual costs actually known?

15. Policy procedure: contemporary, comprehensive, accessible. In the interest of uniformity and consistency of practice, a system must have contemporary policy and procedures that are readily available and understandable. Special attention should be paid to transfers from corrective settings to mental hospitals, forced medication, restraints and isolation, disciplinary proceedings, confidentiality, consent, and suicide. These areas generate the most legal concern and have the clearest legal mandates.

16. Discharge planning. A comprehensive care system should not end at the institution’s walls. Inmates needing care inside are not magically going to be free of that need on their release. Discharge planning begins inside, and appropriate community care, including medication and housing arrangements, will be the hallmark of a comprehensive system.

To reiterate, the above 16 factors are a combination of what is legally required and what is professionally desired. Anyone wishing to evaluate a correctional mental health program might well use these factors as their guide.⁴

Kupers

Using Ruiz for his six essential components, author Terry Kupers, M.D., also adds what he considers 10 essentials of a mental health program for inmates. These are:

1. Comprehensive levels of care
2. Suicide prevention
3. Group therapy and special problems
4. Psychiatric rehabilitation programs
5. Mental health programs for disturbed disruptive prisoners
6. Peer review and quality assurance
7. Continuity of care
8. Confidentiality and access to care
9. Separation of mental health and disciplinary issues
10. Cross-training, including cultural sensitivities

Conclusion

For those hearty souls who want to save money, reduce grief and maintain some of the autonomy lost in litigation, I would suggest that a proactive approach using the 16 components just presented will go a long way to do “the right thing.” Doing an internal or external assessment of your system using these factors as your guide should produce a very good picture of your strengths and weaknesses.

How you change, or if you do, is up to you—until the complaint is served anyway.

End notes

1. This material is a revised version of material found in Fred Cohen, Practical Guide to Correctional Mental Health and the Law (CRI, Inc. 2011) Section 1.12
3. See Agster v. Maricopa Co., 406 F.3d 1091 (9th Cir. 2005), finding no federal peer review privilege and no occasion to adopt the Arizona privilege in a jail death-mortality review case.

Study of Inmates With Schizophrenia Yields Exciting Results

Mental Health Weekly (July 21, 2014), enthusiastically reported the results of a prospective, randomized trial for individuals with schizophrenia. Participants were randomized as to whether monthly injections of Invega Sustenna or one of the most often prescribed oral medications that constitute the great majority of anti-psychotic medications (i.e., Risperdal, Abilify, Haldol, and Seroquel).

The once-monthly treatments with Invega delayed time to relapse by 190 days versus the use of the oral medications.

Mental Health Weekly noted that researchers evaluated 444 adults with a diagnosis of schizophrenia and who were taken into custody by the criminal justice system at least twice in the previous two years, with at least one custody resulting in incarceration. Participants must have been released within 90 days of screening for the trial.

The PRIDE (Paliperidone Palmitate Research in Demonstrating Effectiveness) study did the evaluation across 50 rural and major city sites. There was no mention of differential cost and problems associated with injection versus oral ingestion.