

The Ethical Conflicts of Working in Solitary Confinement

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Abstract

Social work, human service, psychology, and counseling professionals charged with providing professional services to those in solitary confinement are tested by many ethical dilemmas, some quite difficult to resolve. The damaging psychological and medical effects of solitary confinement have been well-documented and the overuse of this type of housing in the US and across the world has been defined by many advocate groups as cruel and inhuman. This leaves helping professionals in a rather precarious position when working within a setting that imposes conditions evidenced to work against the well-being of clients. This article uses several standards of professional and medical ethics to arrive at principled decisions on multiple ethical conflicts present within this specialized field of practice.

Keywords: mental health, professional ethics, ethical dilemma, dual loyalty, solitary confinement, restrictive housing

Introduction

Solitary confinement in the United States (US) has emerged in the national and international dialogue as a salient issue for both prisoner rights and correctional outcomes. Defined as confining an inmate to a cell for a minimum of 22 consecutive hours each day, solitary confinement is often referred to as restrictive housing or various forms of special management/housing, segregation, or isolation (Government Accountability Office, 2013). There are three main reasons why solitary confinement is used—institutional security,

protection, and punishment. Policies differ by institution; however, short term stays of 30 days or less are typically used for punishment of minor rule violations while prolonged or extended solitary confinement (in excess of 30 days) is generally employed for protective custody and institutional security. The most recent data in 2015 from the Bureau of Justice on solitary confinement in the US found that 260,000 state/federal prison and jail inmates were subjected to prolonged solitary confinement within the previous year (Beck, 2015; Kaeble & Glaze, 2016) and on any given day, 80,000 – 100,000 people in the US are being held in restrictive housing (Browne, Cambier, & Agha, 2011; Department of Justice, 2016).

Mirroring the philosophical and penological underpinnings of mass incarceration, entire prisons have been built across the US called “supermax prisons” to house increasing numbers of people in prolonged solitary confinement whose stays are generally indeterminate and often span decades. This overreliance on solitary confinement within prison and jail systems has been touted as necessary to maintain institutional security; however, the international community has become increasingly uneasy about the arbitrary, punitive, and retaliatory nature of its use common in many countries, including the US. The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted by the United Nations in 1984 (and signed by the US in 1994), includes standards for the treatment of prisoners stating that solitary confinement should be limited in scope to only preserving the security of an institution and that due process—initial and ongoing—should

be in place for this provision to all prisoners (United Nations General Assembly, 1984). At the International Psychological Trauma Symposium in 2007, the Istanbul Statement was created based on emerging evidence of the psychological trauma caused by prolonged solitary confinement. This statement was the first to identify vulnerable populations, such as the mentally ill and juveniles, who should be barred from such a practice (Ayan et al., 2007). More recently, a United Nations Special Rapporteur, Juan Méndez, defined the use of solitary confinement in excess of 14 days (and with the mentally ill, juveniles, and pregnant women) as an abusive practice that constitutes cruel, inhuman, and degrading treatment and, in some cases, is tantamount to torture (Méndez, 2013). In addition, the World Health Organization has called upon correctional institutions to use solitary confinement in only extreme cases as the very last resort and for the shortest possible time based on the clear and documented effects of this type of housing on inmate health, mental health, and long-term consequences after release (Shalev, 2014).

From a national perspective, there are multiple organizations actively advocating for the reduction and/or elimination of solitary confinement on local, state, and national levels. Social Workers Against Solitary Confinement, American Civil Liberties Union, National Religious Campaign Against Torture, The Vera Institute, Solitary Watch, Human Rights Coalition, Stop Solitary for Kids, Prison Law Office, and many others have been active in promoting safer alternatives to the use of solitary confinement, supporting legislative initiatives and correctional policies that reduce the use of solitary confinement, and campaigning for position statements from national professional organizations that denounce the use of prolonged solitary confinement in particular. These organizations and the people who drive them oppose the general misuse of solitary confinement, which translates into poorer correctional outcomes and subsequent ethical issues confronting those who choose to work in this field.

Efforts to end prolonged solitary confinement

and its use as a punishment or with vulnerable populations continue to encounter roadblocks but have gained some steam in the US. The most recent standards for federal prisons and accrediting bodies in corrections have started to place limits on the use of solitary confinement in US jails and prisons (American Correctional Association, 2018; Department of Justice, 2016; National Commission on Correctional Healthcare, 2016). Many departments of corrections in the US are coming to realize that prolonged solitary confinement is inconsistent with their mission, is often applied disproportionately, results in higher recidivism rates, does not reduce severe misconduct, and/or ultimately, does not make correctional systems or communities safer (Digard, Vanko, & Sullivan, 2018; Gordon, 2014; Lucas & Jones, 2019).

Practical, fiscal, and ethical considerations clearly require that all disciplines in corrections join together to fight for the basic human rights of those in prison or jail and most importantly, those who are in placed in solitary confinement. However, this advocacy work does not negate the unique set of ethical challenges that exist for the thousands of professionals who currently practice in solitary confinement units across America. Given the nature of this type of confinement, there are ethical conflicts that must be acknowledged and addressed when providing care within such an environment. To ignore these ethical issues or dismiss their implications on practice behavior sets professionals up to perform in a way that is ineffective and potentially unethical. Because professional organizations that guide practice for the helping professions have remained relatively silent on the topic of service in this particular setting, a framework for helping professionals in this specialized field is urgently needed. In this paper, the values and principles central to the provision of care to people in solitary confinement from the perspectives of a variety of helping professions will be explored. Additionally, options for ethical decision-making within this context will be used as a guide for those working on solitary confinement units confronted with multiple ethical conflicts.

Solitary Confinement

Numerous research studies and reports have established that there are destructive psychological, emotional, and health-related consequences after even short periods of time in US solitary confinement units (Ahalt et al., 2017; Browne et al., 2011; Cloud, Drucker, Browne, & Parsons, 2015; Department of Justice, 2016; Grassian, 2006; Grassian & Friedman, 1986; Haney, 2003; Haney & Lynch, 1997; Kaba et al., 2014; Kupers, 2017; Lanes, 2009; Ross, 2007; Smith, 2006; Sullivan & Deacon, 2016). Despite the fact that those in solitary confinement account for less than 10% of the US prison/jail population, over 50% of the completed suicides across this system occur among those in restrictive housing (Kaba et al., 2014; Lanes, 2009). While there are a few studies that stand contrary to the established literature on the topic (Mears & Yahner, 2006; O'Keefe, Klebe, Stucker, Sturm, & Leggett, 2010), there is a dearth of any reliable studies supporting the use of solitary confinement as an effective correctional tool (Briggs, Sundt, & Castellano, 2003). Controlling for other factors, those who spend time in solitary confinement during incarceration are more likely to recidivate (Gordon, 2014; Lovell, Johnson, & Cain, 2007), making restrictive housing antithetical to two of the primary purported correctional goals—rehabilitation and community safety. In fact, many correctional systems routinely release inmates directly from restrictive housing to the community with little to no preparation or step-down assistance with adjustment and re-entry (Digard et al., 2018; McGinnis et al., 2014). There is an inconsistent message when correctional institutions deem a person too dangerous, sick, unstable, or problematic to live among the general prison population but perfectly safe to return directly to the community after months/years/decades in solitary confinement—with little, if any, help. This speaks to the deep disconnect between mission and reality that has plagued correctional systems that rely so much on a practice that is counterproductive.

Safe alternatives to the use of restrictive housing exist in abundance and many correctional

systems have or are currently transitioning toward many of these options. Because over half of those in solitary confinement are there for low-level, nonviolent offenses (Digard et al., 2018), the exclusive use of disciplinary sanctions other than solitary (such as restrictions on incentives) for minor rule infractions will generally reduce the restrictive housing population within most correctional systems by a significant amount without sacrificing their ability to regulate behavior. Policies that automatically or disproportionately place vulnerable populations such as the severely mentally ill, juveniles, and the medically compromised (including pregnant women) into solitary confinement can be eliminated and replaced with more creative solutions. Producing pockets of safe spaces—for example, mental health or assisted living units—in which those among special/similar populations can routinely interact with others and receive the services needed in a more nurturing environment is an especially effective alternative. Institutions that employ such a solution are better able to monitor high risk individuals, promote the dignity and worth of those with special needs, and manifest better overall outcomes for their system. To address inmates with more severe behavioral problems, developing a step-down program that begins within a short time of entry into restrictive housing can provide the necessary services and motivation to address the issues underscoring problematic behavior. Step-down programs typically combine steady mental health services or other types of programming with incentive-based increases in exposure to out-of-cell educational, vocational, creative, social, and/or recreational programming. While these safe alternatives are unlikely to result in 100% success, they are certainly more efficient and effective solutions compared to solitary confinement (Glowa-Kollisch et al., 2016; Kupers, 2017; McGinnis et al., 2014).

Commitment to Client

Whether a client is defined as an individual, couple, family, group, organization, or community, commitment in the form of ethical responsibility to

the client is one of the most basic principles of all helping professions. Professional responsibilities to the client are central guiding factors in ethical decision-making and upon which many other professional principles and specific ethical standards are based. To this end, preambles to ethical codes for human service-related professions speak to the primary importance of recognizing, supporting, and ultimately promoting the dignity, strengths, welfare, worth, and/or well-being of clients (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017; National Organization of Human Services, 2015). Rarely do other interests interfere with this commitment, and generally speaking, there is little that would supersede this commitment in ethical decision making on the part of any helping professional.

Within solitary confinement, the commitment to client extends to the specific individuals who are confined in isolation. The professional roles may be different, however. Some may involve providing direct services (such as assessment, mental health treatment, programming, classification, or case management) while others encompass more administrative, supervisory, legal, or advocacy-related duties. Helping professionals servicing the needs of clients in solitary confinement in any role should believe that those services are in the best interests of their clients and do not pose a threat to well-being. While there may be issues within the practice setting worthy of further consideration, the specific service and behaviors of the helping professional should be squarely focused on this commitment to client. Therefore, the client's dignity, worth, strengths, welfare, and well-being assume a primary position and any ethical decision made would be required to consider the needs of the client, in the context of the service provided, above most other ethical responsibilities.

Policies for the provision of care on solitary confinement units should reflect what we know about the impacts of this type of housing on psychological and health-related functioning. American Correctional Association (2018)

standards specifically set a frequency of weekly mental health contact and daily healthcare rounds for this purpose, at least for prisons. To mitigate risk of harm and support client goals, solitary confinement should be seen as an urgent mental health condition connected to a protocol that secures access to high-quality, high-intensity services with a qualified mental health provider (Winters, 2018).

Another feature within the commitment to client paradigm is the role of client self-determination. Not all people placed in solitary confinement perceive it as an undesirable experience and it is not entirely unheard of (although still exceedingly rare) for some to prefer to serve their time in that type of environment. Perhaps they feel safer there, prefer a single cell, believe the solitude will be advantageous to the work they must do on their case, or have become institutionalized to the solitary environment. Any number of reasons exist as to why someone would choose to be in solitary confinement or at least conclude the potential benefits outweigh the risks. Unless the client has a diminished capacity for decision-making, a preference for solitary confinement should be supported as a product of client self-determination. But if at any time a client begins to experience the adverse effects of solitary confinement and/or simply changes their mind, then a commitment to client on the part of the professional would require support of this altered need or preference immediately.

A final relevant feature within the commitment to client paradigm is confidentiality. Confidentiality and its limits are particularly complicated in many criminal justice system settings and roles. Information shared by a client in jail or prison, on parole, or as part of a mandated program may have significantly more obstacles and limits to confidentiality than in other areas of practice. Security procedures, the Prison Rape Elimination Act (PREA), reporting mechanisms for contraband, and other specific agency policies may present barriers to the level of confidentiality routinely afforded to clients in solitary confinement. Helping professionals should

seek to provide services only in an environment that can offer confidentiality; ACA guidelines require that correctional institutions provide a space in which the content of sessions between a service provider and those living in solitary confinement are not overheard by correctional personnel or other inmates (American Correctional Association, 2018). Providing “services at the door”—meaning delivering services to an individual in a cell where the provider is located outside the cell door—should never be used as an ongoing form of any service, for evaluation or assessment at any time (except in crisis situations), or to exchange any information that is careless or in any way potentially damaging to clients. Services at the door should only occur as a last resort, under urgent conditions when there is no other option, and should focus solely on the resolution of the current crisis. Thus, it is critical that mental health administrators be proactive in ensuring a confidential space for service provision to clients by working with correctional and security counterparts to dedicate personnel and generate specific procedures that accommodate this requirement. Outside of applicable laws or legal mandates, safety of the client, or duty to warn/protect, human service-related professional ethics generally do not promote other breaches in confidentiality (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017; National Organization of Human Services, 2015). If there are additional limits imposed on confidentiality—for example, those pertaining to reporting contraband—then a choice to breach confidentiality falls to the discretion of the professional through the use of deliberate ethical reasoning, and the choice should be made exceptionally clear to the client when beginning services and periodically reinforced throughout service delivery.

Commitment to Employer and Practice Setting

Helping professionals in corrections, as in all other fields, are ethically bound by a commitment

to their employer to follow agency policy but are also expected to inform employers of their ethical responsibilities as a professional. At times, however, there may be unforeseeable agency policies or procedures that constitute a violation of their ethical code of conduct. Situations when agency policy, the needs of the employer, or the actual practice setting come into conflict with an ethical standard of professional practice can be difficult to navigate. Further, correctional institutions and those who work within them are often not bound by the same ethical or professional standards, making it complicated to feel heard and understood.

Dual loyalty in this context is defined as an ethical dilemma in which a professional ethical obligation to a client comes into direct conflict with an explicitly or implicitly understood agency policy and/or third-party interest (Pont, Stöver, & Wolff, 2012). Those in supervisory or administrative positions within correctional systems are most at risk of confronting this ethical dilemma but those in direct service positions might encounter it as well. Ethical standards for human service professionals (Standard 24 & 25), social workers (Code 2.06 a, b & 3.09 b, c, d), psychologists (Code 1.03), and counselors (Code D.1.h) all suggest that constructive efforts should be made within the agency to (1) address the ethical conflict along appropriate channels and among those involved and (2) challenge policies or procedures to eliminate the conflict, enhance client functioning, or reduce potential client harm (American Counseling Association, 2014; American Psychological Association, 2017; National Association of Social Workers, 2017; National Organization of Human Services, 2015). For counselors and social workers, there are additional guidelines to include other avenues such as advancing outside of the agency to professional or accrediting organizations, advocating for improved conditions through public initiatives, and/or voluntary termination of employment if the conflict cannot be resolved internally (American Counseling Association, 2014; National Association of Social Workers, 2017).

In the case of solitary confinement, the

safety of correctional staff and other inmates is the foundation upon which most policies are constructed. Some may argue—with good reason—that correctional policies associated with solitary confinement are more aligned with a punitive culture and/or delivering retaliation; however, the spirit of many of these policies (as opposed to how these policies are implemented) is rooted in a genuine concern for safety that should not be so easily dismissed. Some of these policies are advantageous to the security of the institution and the people who work and live there; others create or contribute to unsafe conditions for clients in solitary confinement that can only be defined as cruel, inhuman, degrading, or torturous.

A decision to use solitary confinement solely for the purpose of protecting inmates and/or staff from immediate harm is a perfectly reasonable course of action. The situation gets a little sticky when due process/review, initial and ongoing, is examined. When someone is placed in restrictive housing, the points and ways in which the system reviews information, formally and informally, for the purpose of reassessing that decision become key indicators of institutional culture. In more progressive systems, these reviews occur very quickly after an initial decision and frequently thereafter using a multidisciplinary team approach (including the client) in a confidential area to assess all available information, including risk of harm to the client caused by this type of confinement and potential safe alternatives, to arrive at an informed decision that offers specific, reasonable steps and a practical timeline off solitary. By contrast, punitive systems implement these reviews very slowly after an initial decision and infrequently thereafter (if at all) using only correctional/security staff, that may not include the client or take place in a confidential area, to justify a decision that has already been made—to extend isolation—without considering the risk of harm to the client caused by this type of confinement, evaluating potential safe alternatives, or offering specific, reasonable steps and a practical timeline off solitary. As you can see, the latter will generate and maintain a high population

in prolonged solitary confinement whereas the former will quickly funnel most people away from prolonged solitary confinement into the most conducive setting that meets their rehabilitation needs.

When solitary confinement policies and/or how they are implemented are likely to create psychological or health-related consequences, such as in the case of prolonged solitary confinement or with vulnerable populations, then these policies should be seen as inconsistent with the ethical standards for helping professionals (United Nations General Assembly, 1982). In these cases, an ethical dilemma exists for those working within a solitary confinement unit—if not any institution that contains this kind of housing and a substandard process for review. In light of this dilemma, any ethical decision-making framework would have to reflect an obligation, at minimum, to attempt to remediate those policies that cause harm to the client or create barriers to healthy client functioning while also balancing the safety concerns of the institution and reducing risk to all.

The Ethics of Evaluation and Participation

Accrediting bodies for correctional institutions generally set standards that require institutions to periodically evaluate the mental fitness of individuals to withstand the solitary confinement environment (American Correctional Association, 2018). These evaluations are to be completed by mental health providers and are used to assess an individual's mental health status, presence of suicidal ideation, current mental health symptoms, and general prognosis/disposition. Further, these evaluations essentially document a person's ability to function in solitary confinement for protracted periods of time. Given what we know about the dangerous effects of solitary confinement, any evaluation that documents someone's capacity to withstand solitary confinement in excess of 14 days (or a member of a vulnerable group for any period of time) places the professional at odds with their ethical responsibilities to their client by

promoting cruel and inhuman treatment (United Nations General Assembly, 1982). The American Psychological Association (2017) recently added a new standard (3.04b) that denies a psychologist the right to participate in or facilitate any type of torture or behavior that is cruel, inhuman, or degrading. While this addition was in response to another problem facing the field of psychology (the use of psychological expertise for enhanced interrogation), it is certainly worth considering here. These restrictive housing evaluations require an action based on professional expertise that creates an avenue for the use of prolonged solitary confinement. If a helping professional possesses knowledge of the damaging effects of prolonged solitary confinement yet chooses to use their professional expertise/credentials to affirm a client's capacity to withstand such effects (outside of those situations covered under self-determination), then they are culpable of facilitating cruel and inhuman treatment.

There is an unfortunate flip side to this evaluation issue, however. When an evaluation documents that an individual is ill-equipped to handle solitary confinement, they are typically placed in a holding cell as a precaution for suicide or self-harm. Stripped of their clothing, personal items, and dignity, they are in worse conditions than a traditional solitary confinement cell. These evaluations thus create a no-win ethical dilemma; the only ethical choice left is to refuse to complete this type of evaluation.

A similar ethical dilemma exists when a helping professional is asked to participate in disciplinary or review committee decisions about solitary confinement classification, especially in cases of prolonged solitary confinement. Because we have established that prolonged solitary confinement, and solitary confinement for any significant length of time with vulnerable populations, are contrary to the ethical standards of professional practice, there would be no situation in which it would be ethical to participate in a decision to impose such a sanction on a client as an ongoing mandate except in those situations covered under

client self-determination. However, it is perfectly reasonable—in fact quite ethical—to participate on a disciplinary or review committee in the position of advocate. Helping professionals can ethically serve on these disciplinary committees to present alternatives to the use of solitary confinement such as increased mental health services, substance abuse treatment, reduced incentives, or other disciplinary sanctions that are more ethical. For review committees, helping professionals can offer context to behaviors and advocate for reduced solitary confinement time, promote increased mental health services in solitary confinement, introduce information on the risk of harm posed by this type of confinement on the client, and work within the system to develop step-down programs and other safe alternatives.

Conclusion

As social work, human service, psychology, and counseling professionals, we have an obligation to ourselves, our clients, our agencies, and our professions to provide services with integrity based on solid ethical standards. Sometimes that isn't easy, and in the case of solitary confinement, it certainly is not. The purpose of this article was to provide information within an ethical framework and process to help those who are currently working in solitary confinement, although some components could easily apply to those working anywhere in the criminal justice system. It was also intended to inform others and increase awareness of what is happening behind the walls of jails and prisons across the US. Join a local/state/national/international group dedicated to addressing this issue, lobby your professional organization for a position statement on solitary confinement, or offer to assist your local jail or state prison system in implementing the safe alternatives outlined in this article. With action, activists and advocates of all kinds can join the fight to reduce or eliminate the use of solitary confinement across the US.

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