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SOCIAL WELFARE ACTION ALLIANCE

Social Workers Against Solitary Confinement,
an Issues Chapter of the Social Welfare Action Alliance

What is Solitary Confinement?

In jails and prisons across the United States, an estimated 80,000 – 100,000 people are being held in Solitary Confinement. For 23 hours a day, they are alone inside a cell the size of a parking space, experiencing no meaningful human contact. Food trays are passed through a flap in the cell door. The length of time they stay in these cells varies from a few days to decades. People are usually placed into "Solitary" for punitive purposes -- for infractions ranging from disobeying orders to assault on staff. Although the public is led to believe that Solitary houses the "worst of the worst," in most cases, the infractions are non-violent. In 2018, Supreme Court Justice Sonia Sotomayor joined a growing chorus of world leaders in condemning this practice, likening it to a "penal tomb."

8-minute film clip- Johnny Perez, solitary survivor, describes his experience in confinement.

Helping Professionals in Solitary Confinement Units -- Providing Treatment or Abetting Torture?

In 2011, the United Nations Special Rapporteur on Torture stated that Solitary Confinement beyond 15 days constitutes torture. Despite this official decree, the practice remains legally sanctioned and deeply entrenched in the United States, posing an ethical dilemma for the healthcare workers who staff these units. In particular, mental health workers must monitor the people held in these cells, assessing them for the mental deterioration and heightened suicide risk that is induced by such extreme isolation. Torn between their professional Codes of Ethics that call for upholding the dignity of all human life, and the demands of their workplace, they are routinely faced with a "dual loyalty" that is not easily remedied.

8-minute film clip, Mary Buser, social worker in mental health department at Rikers Island Solitary Confinement Unit, discusses her responsibilities and the dilemmas she faced in carrying them out.

Alternatives to Solitary Confinement

Despite growing calls for its abolition, Solitary Confinement has been long considered a necessary tool for institutional safety – that is, until the State of Colorado figured out how to keep their prisons safe without it. In 2011, for humanitarian reasons, Colorado began emptying out its Solitary cells, replacing them with "stepdown units" which allowed ever increasing time out of the cell for therapy and socialization. Using this method, over a period of six years, the solitary population decreased from 1,500 to less than five people. Contrary to expectations, the rate of violence in the prisons also decreased, with the biggest drop being assaults on staff. The Colorado template demonstrates that alternatives are effective, and actually create safer institutions. For mental health workers, the Colorado model offers hope of meaningful work in a correctional setting, as opposed to being cogs in an inhumane wheel.

5-minute film clip -- Rick Raemisch, former Executive Director of the Colorado Department of Corrections, testifies before Congress about reforms to solitary confinement in the Colorado State Prisons.

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Contemplation Points:

1. Are there any ethical principals in the NASW's Code of Ethics that solitary confinement violates?
2. How might social work institutions support social workers who are in a dual-loyalty situation?
3. What challenges might a social worker face if they are working in a punitive setting?
4. Do social workers have an ethical responsibility to act when they know of human rights violations? What should they do?

Resources

Lockdown on Rikers: Shocking Stories of Abuse and Injustice at New York's Notorious Jail, by Mary Buser
St. Martin's Press (September 29, 2015)

Hell is a Very Small Place: Voices from Solitary Confinement by Jean Casella, James Ridgeway and Sarah Shourd
The New Press; First Trade Paper edition (September 5, 2017)

Solitary, by Albert Woodfox
Grove Press (March 5, 2019)

Stop Solitary: Advocacy Resources, by the American Civil Liberties Union (online PDF)

Survivors Manual: How to Survive in Solitary Confinement, by the American Friends Service Committee (online PDF, book by mail order)

Solitary Confinement's Mockery of Human Rights, by Mary Buser, Washington Post, April 6th, 2014

Call to Action!

1. Go to the Social Workers Against Solitary Confinement (SWASC) website, join the taskforce, and participate in the monthly call to see how you can help!
2. Click on Unlock the Box (National Campaign to End Solitary Confinement). Find "What You Can Do" tab, pick an action, and then do it!
3. Click on Solitary Watch – National Solitary Confinement Watchdog Group. Review the information about legislative campaigns in all 50 states, find your state, and work on that policy change.

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Psychological, Physical and Societal Consequences of Solitary Confinement

Psychological

The psychological effects of solitary confinement on the human psyche are catastrophic. As Mary Buser, former mental health assistant chief on Rikers Island, notes, “If they did not have a mental health issue before they entered solitary, they do now.” The initial reaction to solitary is often, what psychiatrist Craig Haney terms “isolation panic,” typically followed by depression and feelings of hopelessness. Consequently, people in solitary suffer from depression, anxiety, psychosis and suicidal ideation. Those with an existing mental illness will further deteriorate and the rate of self-mutilation and suicide is far greater than the general prison/jail population.

Physical

Emerging data shows solitary confinement to be adversely impacting physical health and well-being. Growing neuroscientific research has emphasized that social interaction and environmental stimulation are vital for normal brain function. Dr. Brie Williams, who has examined numerous people in solitary confinement notes that, for older individuals with heart conditions and/or diabetes, a recommended exercise protocol is impossible, given the severely restricted cell size, hastening death. In addition, she points out that limited access to sunlight results in a Vitamin D deficiency, increasing the risk of bone breaks, fractures, and may also be a risk factor for fatal outcomes of cancer, cardiovascular disease, and other chronic inflammatory illnesses. Furthermore, Dr. Williams points out that for older adults, the sensory deprivation of isolation exacerbates confusion and memory loss. In addition, vision issues have been noted as a result of small cell space interfering with long distance sight, so that after release from solitary, eyesight problems are common. As more is understood about the physical impact of solitary, it stands to reason that examples of bodily harm will continue to emerge, as the human body was not meant for a confined, solitary existence.

Societal

Contrary to the idea that the roughly 80,000 people in solitary confinement are separate and apart from the larger society, it should be noted that better than 90% of the incarcerated population will be released at some point, including those in solitary. For a person in solitary whose legal sentence is complete, in most states, that individual will be released directly to the streets, with no treatment for the trauma of solitary. In an extreme example of this potential danger, in 2013, Tom Clements, the Director of the Colorado Department of Prisons, was gunned down and killed on his own doorstep by a man who had just been released from a solitary cell to the streets. Ironically, Clements was in the process of attempting to reform solitary confinement. His successor, Rick Raemisch, continued this mission, successfully reforming solitary in the State of Colorado. In the process, Raemisch posed a sobering question: Do we want people coming out better or worse than when they went in? The answer to this question has implications for all of us.

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Contemplation Points:

1. Why would someone with a known mental illness be placed in solitary confinement?

2. What are the reasons anyone would be placed in solitary?

3. Should physicians treat people in solitary for medical issues when the solitary setting itself only exacerbates the medical issue?

4. Can you think of other ways that the larger society may be impacted by the release into the community of someone formerly held in solitary?

Resources:

The Brain in Solitude: An (Other) Eighth Amendment Challenge to Solitary Confinement, Federica Coppola
Journal of Law and the Biosciences, 1–42 (2019) doi:10.1093/jlb/lsz014

Older Prisoners and the Physical Health Effects of Solitary Confinement, Brie Williams, MD
American Journal of Public Health, Am J Public Health, 2016 December: 106(12): 2126-2127
Ncbi.nlm.nih.gov

Change is Possible! Mariposa McCall, MD, Social Workers Against Solitary Confinement, socialworkersasc.org

Expert Report of Terry A. Kupers, MD, MSP, Eastern Mississippi Correctional Facility, aclu.org

Colorado Springs Independent: "**Dean Williams might remind you of someone – murdered prison chief, Tom Clements**" csindy.com

World Medical Association (WMA) / Solitary Confinement

Call to Action!

1. Go to the Social Workers Against Solitary Confinement (SWASC) website and join this task-force in promoting a conversation surrounding the psychological, physical, and societal effects of solitary confinement.
2. Read the article on the PBS website called, "What Does Solitary Confinement Do To Your Mind?" and consider becoming a pen pal to someone in solitary confinement as a way to help them "get through" that experience. Go to the Solitary Watch website to learn more about their "Lifelines to Solitary".
3. Contact your department of corrections or local jail to see about ways you can volunteer on a solitary confinement unit to help those suffering in that environment.

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Dual Loyalty in Solitary Confinement

The literature is clear that prolonged solitary confinement (confinement in excess of 15 consecutive days) is linked to severe psychological and health-related consequences that could be permanent - leading to poorer outcomes, higher recidivism rates, and even early death. Through this lens, helping professionals must conclude that prolonged solitary confinement is not in the best interests of their clients' well-being. This creates an ethical dilemma between a commitment to the client and a commitment to the practice setting/agency when employment in this particular practice area is accepted. This ethical dilemma is known as "dual loyalty", in which a conflict exists between opposing ethical codes that involve professional loyalties. Some important issues to consider when faced with dual loyalty in this situation are:

- Whether or not a professional believes the services being provided are in the best interests of client well-being despite the environmental conditions of solitary confinement.
- Whether or not a professional is able and/or willing to witness the suffering of others as part of the delivery of their services.
- Whether or not a professional can make reasonable attempts to remediate the institutional policies driving the use of prolonged solitary confinement and/or proactively advocate for clients to be released from solitary confinement as soon as possible.

(Read about Dr. Ali Winters, a social worker who worked as a mental health provider in solitary and faced this dilemma.

Other Ethical Issues faced by Helping Professionals in Solitary Confinement Units

When working on a solitary confinement unit, there are multiple ethical conflicts that can arise, either as part of general professional service or the unique tasks required for a particular position. When confronted with these ethical issues, the key is to generate professional decisions based exclusively on ethical principles/codes with client well-being as a central tenet while also understanding the need for safety and security.

Here are some common ethical conflicts inherent to working with those in prolonged solitary confinement:

- Professionals may be asked to participate in disciplinary or placement reviews in which clients are "sentenced" to solitary confinement or their stay on solitary confinement is extended.
- Those with a severe mental illness, those who are members of racial/ethnic oppressed groups, and those who identify as LGBTIQ2S are disproportionately placed in solitary confinement.
- Some clients may prefer to be placed in solitary confinement, at least temporarily, despite the dangers associated with this type of housing assignment.
- In solitary confinement, it often takes one or more correctional officers to transport a client to a private area, making it difficult to offer confidential services.
- Professionals may be asked to complete a psychological evaluation designed to assess and document a person's capacity to withstand the effects of prolonged solitary confinement.
- Because prolonged solitary confinement causes severe psychiatric problems, medication is often used to manage the effects of the environmental conditions on confinement.

Supplemental Reading:

Winters, A. (2019). The ethical conflicts of working in solitary confinement. *Journal of Social Work Values and Ethics. 16*(2), 18-27.

Contemplation points:

1. What are the steps you should take in resolving an ethical dilemma like dual loyalty?
2. If a professional decides to maintain employment as a resolution of dual loyalty, what steps would they need to take in order to ethically do so?
3. If a professional decides to terminate employment as a resolution of dual loyalty, what steps would they need to take in order to ethically do so?
4. What are some self-care techniques you could use to manage your response to witnessing client suffering?
5. What are some actions an ethical helping professional would take to remediate institutional policies regarding solitary confinement or advocate for their clients under such conditions?
6. Is it ethical for a professional to participate in an agency decision that would likely result in dangerous outcomes for clients?
7. What does your Code of Ethics tell you about advocating for social justice - especially for marginalized, vulnerable, and oppressed groups?
8. What ethical code tells you that confidential information should only be disclosed in a private setting in which confidentiality can be ensured?
9. What can a helping professional do when they cannot provide needed services to clients?
10. What is your city or state doing to address the issue of solitary confinement?
11. What can you do, as a professional, to advocate for change in the use of solitary confinement?

Additional Suggested Readings:

Ahalt, C., Haney, C., Rios, S., Fox, M. P., Farabee, D., & Williams, B. (2017). Reducing the use and impact of solitary confinement in corrections. *International Journal of Prisoner Health, 13*(1), 41-48.

Brinkley-Rubinstein L, Sivaraman J, Rosen DL, et al. Association of Restrictive Housing During Incarceration With Mortality After Release. *JAMA Netw Open.* 2019;2(10):e1912516.

Department of Justice. (2016). *Report and Recommendations Concerning the Use of Restrictive Housing*. Washington, DC.

Grassian, S. (2006). Psychiatric Effects of Solitary Confinement. *Wash. U. J.L. & Pol'y, 22*, 325-384.

Haney, C. (2003). Mental Health Issues in Long-Term Solitary and "Supermax" Confinement. *Crime & Delinquency, 49*(1), 124-156.

Kupers, T. (2017). *Solitary: The Inside Story of Supermax Isolation and How We Can Abolish It*. Oakland, California: University of California Press.

National Commission on Correctional Healthcare. (2016). Solitary Confinement (Isolation) *Position Statements* (pp. 6). Chicago, IL: National Commission on Correctional Healthcare.

Pont, J., Stover, H., & Wolff, H. (2012). Dual Loyalty in Prison Health Care. *American Journal of Public Health, 102*(3), 475-480.

United Nations General Assembly. (1994). Convention against torture and other cruel, inhuman or degrading treatment or punishment. (Treaty Series, vol. 1485).

Winters, A. (2018). Alone in isolation: A clinician's guide to women in solitary confinement. *Criminal Behaviour and Mental Health, 28*(3), 217-222.

Call to Action!

1. Go to the Social Workers Against Solitary Confinement (SWASC) website and join this task-force in promoting a conversation surrounding professional ethics and solitary confinement.
2. Watch "Last Days of Solitary" and consider the ethical implications related to the actions taken by the Warden in transitioning away from the use of solitary confinement.
3. Go to the Solitary Watch website and consider participating in their "Photo Requests from Solitary" program.
4. Contact your state department of corrections and request their policies related to solitary confinement. Create recommendations on how your state can implement safe alternatives to solitary confinement.

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Alternative Policy to Solitary Confinement

While it has been clearly established that the wide use of solitary confinement in our nation's jails and prisons is torturous and inhumane, there are certain situations that arise in these institutions that call for interventions. Most notably, violent behavior that poses a threat to correctional staff, civilian workers and to the larger incarcerated population, must be addressed.

The position of SWASC is aligned with the United Nations Mandela Rules which state that anything beyond 15 days in solitary constitutes torture. Therefore, no one should be held in solitary confinement beyond 15 days.

Furthermore, solitary confinement should be entirely prohibited for the following populations:
Women
Those with a severe mental illness
Juveniles
Non-violent offenders
No solitary in the guise of "protective custody" for LGBTIQGNC2S+ people (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Gender Non-Conforming; Two Spirit, Indigenous/First Nation Status; Plus)

Although there are many emerging models of humane alternatives to solitary, in cases of violent behavior, SWASC supports the "Stepdown Program" developed by the Colorado Department of Corrections, that four SWASC members personally observed. Rather than isolating these offenders into solitary cells, which is proven to increase violence once the individual is released, this program temporarily separates the individual, while simultaneously providing therapeutic mental health support to address underlying issues.

This program operates as follows:

Highest level – 4 hours out of cell with therapy plus one hour of recreation
Mid-Level – 4 hours out of cell with therapy plus recreation/socialization with 8 others
Lowest Level —6 hours out of cell with therapy, plus recreation/socialization with 16 others

The primary goal is for the offender to work from the highest level to the lowest, with the goal of a successful re-entry into General Population and ultimately a successful re-entry into the community.

Finally, SWASC endorses the Colorado Department of Corrections policy of never releasing someone from any form of solitary confinement directly to the streets when a sentence is completed. A transitional program is utilized to help the person adjust to the impending change, which is also a safety measure for the community at large.

These measures not only eliminate the barbaric use of solitary, but they are proven to increase institutional safety, and ultimately, community safety.

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The international organization, "Physician's for Human Rights" believes that "health professionals are uniquely positioned to prevent serious human rights abuses."

They have delineated twelve recommendations for healthcare practitioners working in settings that are prone to ethics compromises:

1. Establish professional practice standards that address the problem of dual loyalty and human rights.

2. Where violations of professional standards take place, hold members accountable.

3. Facilitate adoption of self-audits by health services to complement application of standards.

4. Make available advisers and counselors.

5. Provide direct support for health professionals in high-risk situations.

6. Establish or facilitate an independent oversight and reporting structure to play a monitoring and/or ombudsman role.

7. Issue newsletters and create websites to raise awareness in the professions and the public.

8. Initiate and support ongoing ethical and human rights training.

9. Ensure that constitutions of national professional organizations establish the organization as independent of the state and state policy and that the organization can exercise this independence in voicing concerns or criticisms of state policies.

10. Submit shadow reports on national report to United Nations treaty and monitoring bodies.

11. Advocate for legal, administrative, and social changes that will enable health professionals to respect, protect and fulfill the human rights of their patients.

12. To implement many of the above mechanisms, national associations may have to develop plans and invest resources to increase members' support for these organizational actions.

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Contemplation Points:

1. Why do you think Colorado broke with convention and created humane alternatives to solitary?

2. Why are other states resistant to change?

3. Does the use of Solitary Confinement make correctional institutions more manageable?

4. Overall violence in the Colorado jails actually decreased with the solitary confinement reforms. What do you think accounts for this?

Resources

National Commission on Correctional Healthcare (NCCHC)
Solitary Confinement:
https://www.ncchc.org/solitary-confinement

American Correctional Association (ACA)
Solitary Confinement Standards:
http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards___Accreditation/Standards/Restrictive_Housing_Committee/ACA_Member/Standards_and_Accreditation/Restrictive_Housing_Committee/Restrictive_Housing_Committee.aspx?hkey=458418a3-8c6c-48bb-93e2-b1fcbca482a2

National Institute of Corrections (NIC)
Solitary Confinement:
https://nicic.gov/tags/solitary-confinement

US Department of Justice (DOJ)
Solitary Confinement:
https://www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing

Call to Action!

1. Go to the Social Workers Against Solitary Confinement (SWASC) website and join this task-force in promoting safer alternatives to solitary confinement through legislative action and advocacy on the state/national level.
2. Explore the Vera Institute of Justice and how they are helping different jurisdictions end their reliance on solitary confinement. Contact your state department of correction to see if they plan to use this resource!
3. Read the ACA Standards on Solitary Confinement. See if any of your local or state institutions are accredited through the American Correctional Association (ACA) and seek to ensure they are following those standards.

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Do We Have a Right to Torture Prisoners and Violate their Human Rights?

What crime warrants a punishment that damages brain cells and produces memory loss, cognitive decline, and depression? Should we punish people by damaging the hippocampus of their brain, thereby inducing an out of control chronic stress response?

When we isolate people from humanity, we hinder their reintegration into society and their successful rehabilitation

In prison, among those already separated from society, there is still a strong impetus to separate further those seen as problematic, from the general prison population.

Thus, we come to solitary confinement as a means of control within a population already isolated from society.

Today there are an estimated 80,000 people, mostly men, in solitary confinement in prisons, jails, youth facilities, and detention centers. Men of color are overrepresented in isolation, while whites are underrepresented. They are confined to a cell the size of a parking space for at least 22 hours a day. They are tortured by both sensory deprivation (e.g., gray or white concrete and steel cells; no access to fresh air and sunlight) and sensory overload (e.g., unremitting fluorescent lighting and constant deafening sounds). It is hard to imagine such trauma boding well for a successful return to society.

The United States is turning against solitary confinement as a human rights abuse

Solitary remains a mainstay of prison management and control. This is because many policymakers, corrections officials, and members of the public still subscribe to **common misconceptions** —including solitary being used only as a last resort for the most violent offenders. In truth, solitary is used as a "first resort" for the most minor of offenses (e.g., possession of too many postage stamps), and is enforced at the discretion of correction officers without due process, using unconstitutional "confidential information" that cannot be viewed or challenged, and often is unreliable.

Supreme Court Justice Sonia Sotomayor's statement on Solitary Confinement as a violation of the 8th amendment that prohibits cruel & unusual punishment

Justice Sotomayor wrote, regarding a Colorado case, "A punishment need not leave physical scars to be cruel and unusual. As far back as 1890, this Court expressed concerns about the mental anguish caused by solitary confinement. We are no longer so unaware. Courts and corrections officials must accordingly remain alert to the clear constitutional problems raised by keeping prisoners like Apodaca, Vigil, and Lowe in 'near-total isolation' from the living world, in what comes perilously close to a penal tomb."

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It Doesn't Have To Be This Way

United States, Colorado: A promising effort in Colorado was conducted by Rick Raemisch, former Executive Director of the Colorado Department of Corrections. Colorado ended the use of prolonged Solitary Confinement and limits its use to **15** days at a time. They follow the principles of the United Nations Mandela Rules, which limit isolation to **15** consecutive days. Colorado uses solitary confinement only sparingly, for very serious disciplinary issues. Prisoners must be provided services for both mental health issues and reentry, both of which will help them progress while incarcerated and when they return to their communities. This approach has had good results so far.

Germany: Disciplinary measures are meted out judiciously and incrementally and warnings are liberally given. A prisoner may be isolated only as a last resort and for as long as necessary, for a maximum of four weeks.

Great Britain: Referred to as cellular confinement for attacks on other prisoners and guards. Adults may be held for 21 days and 10 days for those under 18. A rough estimate of segregated use is 500 at any given time, as compared to the United States with a total of 80,000 to 100,000 in prisons, with another 25,000 in supermax facilities (state and federal), plus untold thousands in jails, juvenile facilities, and detention centers.

Spain: Isolation cells are used as mechanisms of last resort, but are used as a constant threat and powerful weapon against prisoners to maintain discipline and obedience. Isolation in cell may not exceed 14 days and is limited to seven weekends, which may not exceed two months.

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Contemplation Points:

- 1- Are there any ethical principals in the NASW's Code of Ethics that solitary confinement violates?
- 2-Review the Universal Declaration of Human Rights
  .https://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf
- 3- Consider the human rights that *can't* be taken away from prisoners and the state cannot restrict them in any circumstances. How do we see these being violated in the US prison system?

  - the right to life (Article 2)
  - the prohibition on torture (Article 3)
  - the right to a fair trial (Article 6)
  - freedom from slavery (Article 4)
  - protection from retrospective laws (Article 7)

Resources:

"The Link Between Race and Solitary Confinement: Men of color are overrepresented in isolation, while whites are typically underrepresented" by Juleyka Lantiqus- Williams December 5, 2016, The Atlantic,
https://www.theatlantic.com/politics/archive/2016/12/race-solitary-confinement/509456/

"Safe Alternatives to Solitary Confinement: A Human Dignity Approach"
Vera Institute of Justice 2019
https://www.vera.org/research/safe-alternatives-to-solitary-confinement

"Sotomayor Pens Stinging Rebuke of Solitary Confinement," by Barbara Leonard 2019, TheCourthouseNews.com
https://www.courthousenews.com/sotomayor-pens-stinging-rebuke-of-solitary-confinement/amp/

"Humanity in Prison Questions of definition and Audit" by Andrew Coyle, 2003 International Centre for Prison Studies
https://www.prisonstudies.org/sites/default/files/resources/downloads/humanity_in_prison.pdf

Call to Action!

1. Go to the Social Workers Against Solitary Confinement (SWASC) website and join this task-force in fighting against this torture and promoting the use of safer alternatives to solitary confinement.
2. Explore the National Religious Campaign Against Torture's work on addressing the torture of solitary confinement and check out the State Campaigns through this organization to see if your state is participating.
3. Join the American Civil Liberties Union (ACLU) in advocating against the use of solitary confinement in US prisons and fighting for prisoner rights in other critical areas.