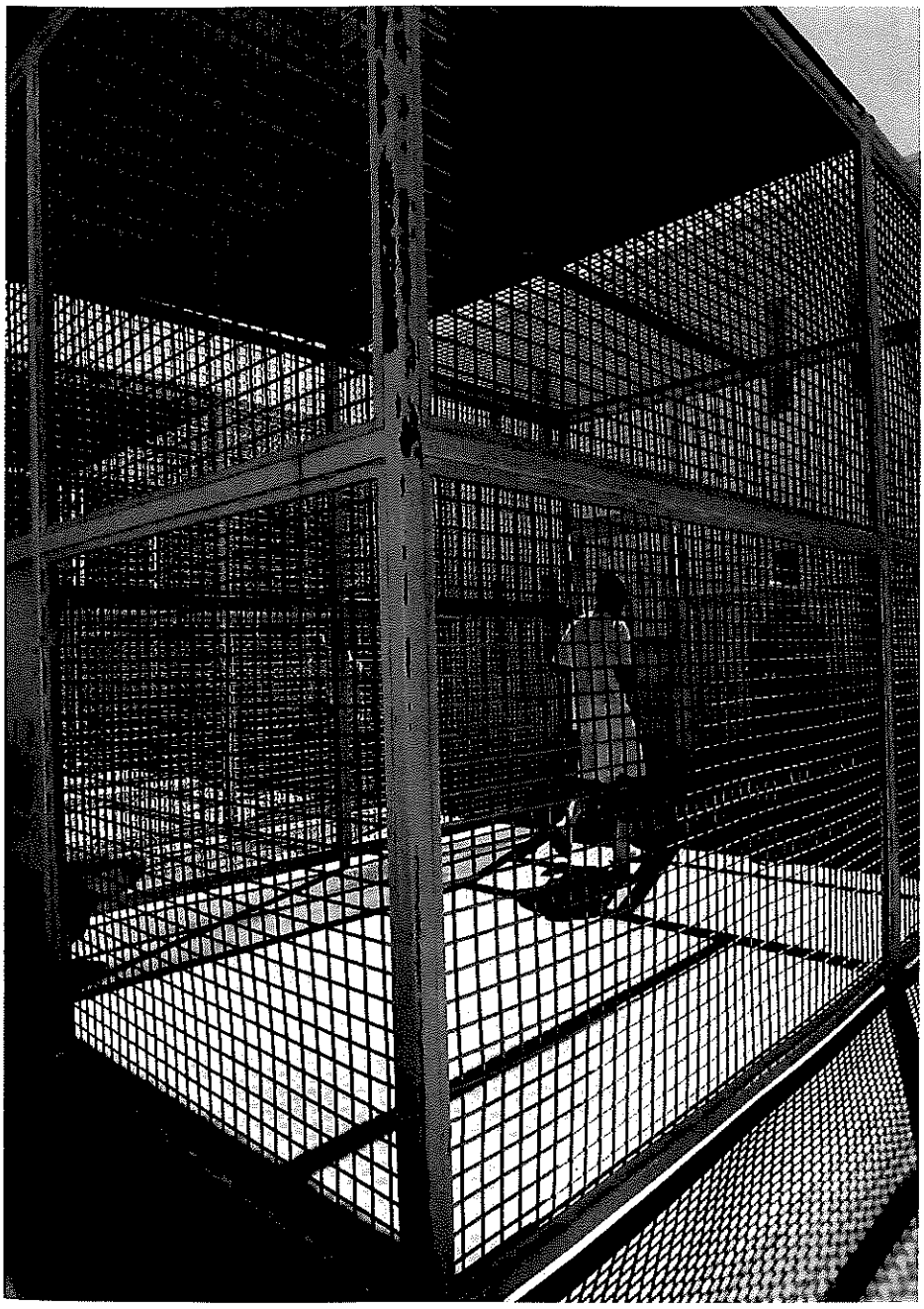
SPEAK OUT

Questioning solitary confinement

Is administrative segregation as bad as alleged?



Studies vary widely on the effects of administrative segregation.

By Robert D. Morgan, Ryan M. Labrecque, Paul Gendreau, Taylor R. Ramler and Brieann Olafsson

Disclaimer: *The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the American Correctional Association.*

Administrative segregation (AS) — often referred to as solitary confinement — involves the isolation of an inmate in a setting that provides little opportunity for meaningful contact with other individuals. The use of AS in North American correctional institutions has risen since the 1980s, as have concerns about its effect and utility.[1] Current estimates suggest that nearly one-fifth of all jail and prison inmates in the United States,[2] and one-quarter of those in the Canadian federal prison system, have spent some time in AS.[3] Policymakers and corrections officials insist that the judicious use of AS increases safety, order and control in prison and beyond.[4] Those critical of AS, however, argue that it is an overused correctional practice that produces many damaging effects on inmates, staff, prison life and the communities to which inmates are returned.[5]

Much has been written about the potentially harmful effects of AS. By far, the greatest area of concern involves its purported negative physiological and psychological effects.[6] Numerous reports suggest that AS causes myriad negative mental health problems.[7] Also, it is widely believed that offenders with pre-existing mental illnesses are at an increased risk for suffering the deleterious effects of such placement.[8] Further, it is commonly accepted that inmates who return directly to the community from AS have poorer postrelease outcomes than those who are transitioned from the general prison population.[9]

The collection of studies that are used to support these claims, however, do not paint a complete picture of the effects of AS.[10] It is noted, for example, that the majority of the AS research investigating psychological outcomes consists of case studies of small, non-random or extreme samples of inmates and do not include pre-AS baseline functioning or appropriate comparison groups.[11] Further, much of the behavioral outcome literature is limited to studies employing the weakest type of research methodology, which fails to account for the influence of many theoretically relevant variables (e.g., institutional behavior, violent behavior, criminogenic risk) on such behavioral outcomes.

The need for a research synthesis

Given the conflicting opinions on the effects of AS, it is not surprising that its use has become a hotly debated and litigated issue. In our review, two groups of researchers undertook two independent meta-analytic reviews, in an unplanned systematic replication, to determine what effect AS has on inmates' physical and mental health functioning, as well as to determine behavioral outcomes (e.g., recidivism).[12] The statistical results, including methods and calculations, of the two research groups were unknown to each other until the preparation of the final manuscript. The comparison of these two meta-analyses is fortuitous, given that replication is a hallmark of good science[13] — the same goes for meta-analyses.[14] Moreover, due to the sensitivity and controversy related to ethical and legal issues about the humane care of inmates, replication becomes even more critical.

AS's use has become a hotly debated and litigated issue

Research synthesis 1

Utilizing meta-analytic techniques, coupled with database and ancestral reference searches, one article identified a total of 14 studies pertaining to AS and inmate well-being that met specified eligibility criteria.[15] Studies were deemed eligible for inclusion if they

- Involved persons experiencing AS as part of legal custody.
- Included a comparison condition and an outcome variable.
- Reported data adequate for an effect size calculation.

Of the 14 studies, the majority was published post-2001, actually took place in the United States and sampled adult, male inmates. Studies meeting the inclusion criteria were subsequently coded for strength of design (i.e., whether each used a comparison group similar to the treatment group in terms of age, criminal history, etc.) as well as the outcome variable(s) examined, including

- Psychological indicators (e.g., anxiety, depression).
- Medical/psychophysiological indicators (e.g., physical health).
- Behavioral indicators (e.g., recidivism rate and institutional infractions).

The impact of AS was examined using a standard effect size (ES) to indicate the magnitude of the effect of AS on behavioral and mental health functioning. Positive effect size values represent a deleterious effect, such that AS was associated with an increase on the outcome variable. In contrast, negative values indicated a beneficial effect, such that AS was associated with a decrease on the outcome variable. A total of 65 effect sizes among the three outcome variables were analyzed: psychological ($k = 50$), medical/psychophysiological ($k = 6$) and behavioral ($k = 9$).

The collective effects examined in this research synthesis suggested AS generally exerts a small detrimental effect upon inmates' mental health

and physical functioning. The ES for psychological outcomes suggests AS placement yields slightly negative to slightly positive effects upon such areas as depression, anxiety and psychosis, depending upon the specific construct. Likewise, AS was shown to contribute negatively to the medical/psychophysiological variables of physical health and sensory arousal, in addition to the behavioral outcome of postrelease recidivism. Nevertheless, AS was also shown to have a suppressive effect upon institutional misconduct, such that inmates placed in AS showed less proclivity to violate rules while incarcerated. Taken together, these findings yield important implications for corrections professionals in the areas of treatment planning, rehabilitative/vocational service provision and administrative policymaking, among others.

Research synthesis 2

A second research synthesis reviewed 19 documents that were published in English, contained outcomes specific for those placed in AS and included sufficient data for effect size calculation.[16] These 19 documents included 9,823 inmates in AS and 131,169 non-AS inmates, and 144 total effect sizes were obtained. Results indicated small effects for social and cognitive impairment as well as moderate effects for impaired behavioral functioning and physical and mental health functioning. There was also a small to moderate effect for increased antisocial indicators (e.g., rearrest, recidivism/revocation, hostility/anger).

Collectively, the findings from these two meta-analytic reviews indicated that the adverse effects on outcomes of interest resulting from AS ranged from small to moderate for the time periods observed in the included studies. These investigations further revealed considerably smaller ES among studies with stronger research designs compared to those with weaker designs. That is, the stronger the research design (which presumably provides a better evaluation of the phenomena of interest), the lower the ES. Notably, these results are clearly contradictory to much that has been written about the demonstrable effects of AS.[17]

To place these results in context, it is relevant to compare the magnitude of the effects resulting from confinement in AS to the effects resulting from general incarceration (i.e., non-segregated imprisonment). Our results were very similar to results obtained from investigations on the general effects of incarceration.[18] In other words, as a general matter, the quantifiable effects resulting from segregation are comparable to the quantifiable effects resulting from incarceration (see Figure 1).

Discussion

The literature clearly demonstrates that some inmates experience harm as a result of their AS experience;[19] however, these harmful experiences are not universal. Rather, it seems that some inmates in AS will experience negative effects, others will improve and some will remain unchanged. Further, when negative responses do occur in AS, they are typically not as severe as often described by critics of AS. As our meta-analyses revealed, one can expect the experience of AS to produce mild to moderate health and mental health effects comparable to the effects of general incarceration.

Logically, one might ask, "How is it possible to place someone in AS for a lengthy period of time without it causing a harmful effect on the individual?" It is our opinion inmates, like most people, adapt to

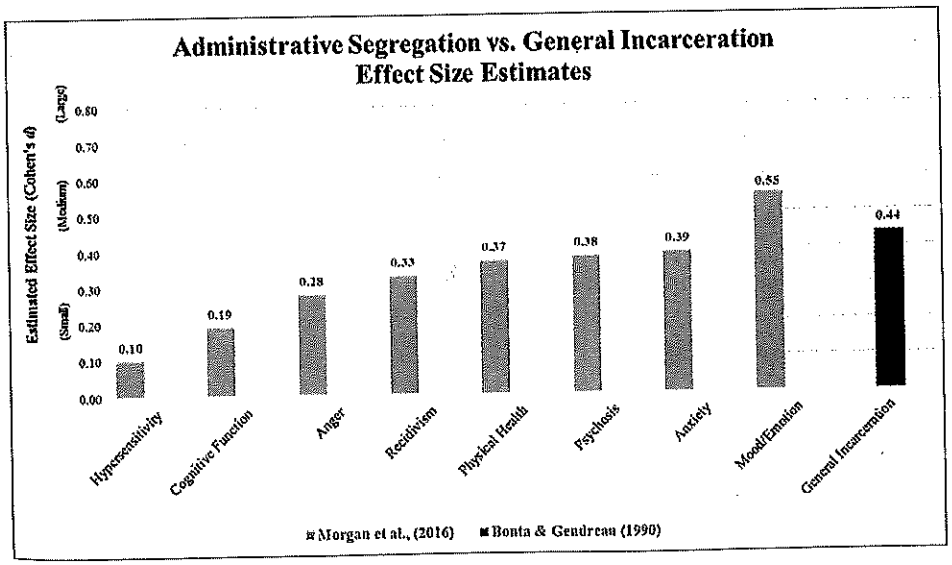


Figure 1.

Chart courtesy of the authors

their environment, whether it be a general prison population setting or an AS environment. This opinion was supported and clearly articulated by an inmate to our lead author, Dr. Robert Morgan. According to this inmate, incarcerated individuals are generally adept at serving time in correctional facilities prior to their AS placement. To anyone unaccustomed to serving time in prison, AS would seem daunting and completely overwhelming; however, experienced inmates are skilled at coping with incarceration. For them, AS is simply another adjustment in the process of confinement.

In support of this coping perspective, one article described and measured changes in the mental health symptoms of segregated inmates over time in three Canadian federal institutions.[20] After 30 days, segregated inmates endorsed more symptoms of depressed mood and anxiety, as well as poorer psychosocial adjustment, than their general population peers. However, segregated and non-segregated inmates all improved over 60 days on measures of depression, psychosocial adjustment, hopelessness and anxiety. The article concluded that segregated inmates may have "generally adapted and coped well with the conditions of today's Canadian federal administrative segregation."[21]

One question in particular that remains largely unaddressed is as follows: What are the effects of long-term AS? The empirical literature to date consists of inmates serving less than one year in segregation. Little is known about the effects of long-term AS incarceration. In fact, in the only empirical investigation to date that examines AS commitments greater than one year in duration, one article found that inmates segregated between one and four years evidenced increased symptoms of depression compared to their non-segregated peers; however, scores remained in the sub-clinical range for both groups of inmates.[22] Further, inmates in long-term AS did not demonstrate a worsening of psychological symptoms as time in restrictive housing increased.

These harmful experiences are not universal

Although we believe the effects from AS are not drastically different than those produced by incarceration in general (see Figure 1), this should not be interpreted as an endorsement for the wide-spread and long-term use of AS. Although there are no definitive studies indicating maximum cutoffs, we recommend a general principle of "shorter is better." Furthermore, AS is contraindicated for some inmates and should only be used as a last resort for inmate, staff or institution safety while seeking a transfer or placement in a more appropriate setting. Further, some inmates (e.g., juveniles, individuals with severe mental illness, inmates at risk for suicide) should be closely monitored during very brief periods of segregation. Consistent with correctional psychiatry expert Jeffrey Metzner,[23] we advocate for the development and implementation of best practices in AS to minimize risk and harms where they do occur.

Recommendations

Limit the use of AS for inmates with severe mental illness (e.g., disorders characterized by psychosis or other thought disorder, mania or severe depression) except in extreme instances in which the inmate presents a significant threat to other inmates/staff or the security of the institution. Although we recommend limiting the use of AS for inmates with severe mental illness, we recognize that severe mental illness does not eliminate antisocial tendencies warranting AS placement. The intent here is to eliminate the use of AS as a behavioral management strategy for symptoms of mental illness.

Although research has not demonstrated harm to juveniles placed in segregation, our recommendation is to limit the use of AS for juvenile offenders (i.e., inmates younger than age 18). In fact, although disciplinary segregation may be necessary as a form of behavioral management, we discourage the use of AS with indeterminate placement periods for juveniles except in extreme and rare circumstances.

Provide therapeutic and step-down programs for inmates serving significant time in AS. Examples of therapeutic programs include "Stepping Up, Stepping Out: A Mental Health Treatment Program for Inmates Detained in Restrictive Housing"[24] and "Taking a Chance on

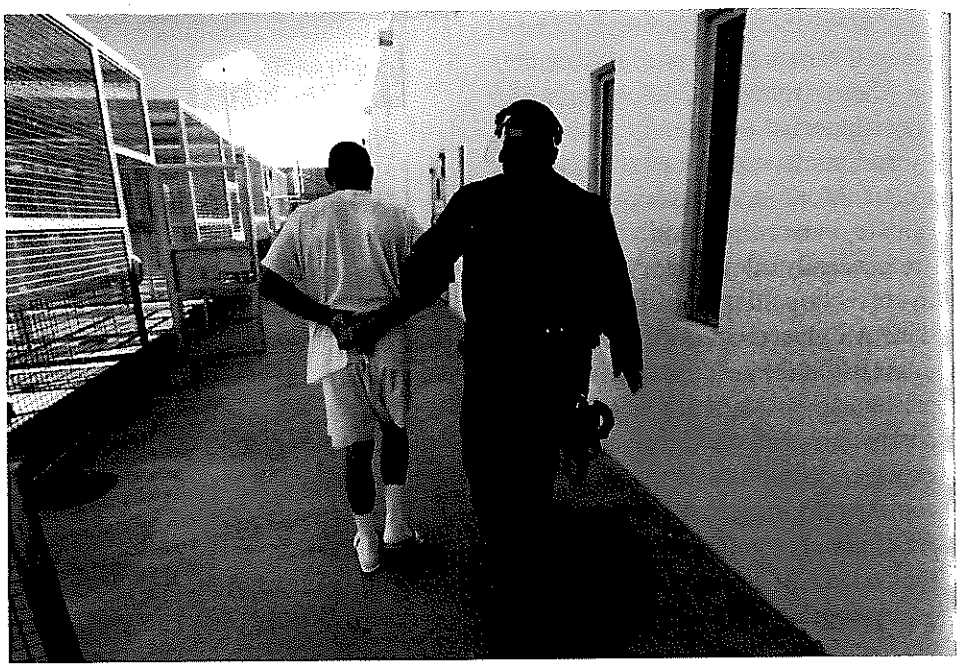
Change."[25]

Transfer inmates scheduled for community release out of AS approximately six months before their release date. Although data does not support a specific transfer time, it is clear that inmates released from AS directly to the community fair worse than inmates not released directly from AS; thus, we hypothesize that six months will allow for a sufficient adjustment period to optimize chances for a successful community reintegration.

Correctional systems remain responsible for providing basic medical and mental health services while housing inmates in AS. To ensure inmates that decompensate during their placement in AS, upon admission, a thorough medical and mental health evaluation should be conducted as a means of providing baseline data.

Transition inmates displaying symptoms of decompensation (physical or mental health) out of AS. Mental health rounds should be conducted on a minimum of a weekly basis (and possibly more frequently for non-AS type of segregation), and rounds should include verbal contact with any inmate who is deemed at risk for decompensation (e.g., inmates with a history of mental illness, inmates placed in AS shortly after their incarceration or who otherwise have a history of more time in AS than in general population, inmates with a history of suicide ideation/gestures).

Little is known about the effects of long-term AS incarceration



When recommending administrative segregation, shorter is better.

Mental health professionals responsible for rounds should consult with correctional staff to identify behavioral changes or possible decompensation in inmate functioning. Inmates placed in AS should receive clearly articulated and specific targets of behavior (e.g., disciplinary free for 60–90 days) that must be met for release consideration. Progress toward these specific behavioral markers should be routinely assessed with results of these ongoing assessments provided to the inmate.

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Photos courtesy California Department of Corrections and Rehabilitation (CDCR)

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