



SJ 25 STUDY: REVIEW OF RESTRICTED HOUSING STANDARDS AND GUIDELINES

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Law and Justice Interim Committee
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MONTANA STATE LEGISLATURE

REVIEW OF RESTRICTED HOUSING STANDARDS AND GUIDELINES

BACKGROUND

In 2017, the Montana Legislature requested that an interim committee study the extent of the use of solitary confinement in Montana. The Legislative Council assigned the Senate Joint Resolution 25 study to the Law and Justice Interim Committee (LJIC). This paper reviews existing correctional standards related to restricted housing and provision of health services. It also includes several statements of best practices for restricted housing or recommendations from recent studies of the correctional housing practice but does not include standards for juveniles or for county detention facilities, also known as jails. Future papers will review those standards as well as Montana Department of Corrections policies and Montana State Prison procedures.

Note: This paper is a working paper, meaning it could be updated for future LJIC meetings with additional standards or guidelines or with other analysis of the standards or DOC policies and procedures.

REVIEW OF RESTRICTED HOUSING STANDARDS AND GUIDELINES

American Correctional Association Standards

The American Correctional Association (ACA) is a professional organization of corrections professionals. One of its goals is to “develop standards that are based on valid, reliable research and exemplary correctional practice.”¹ Those standards “represent fundamental correctional practices that ensure staff and inmate safety and security; enhance staff morale; improve record maintenance and data management capabilities; assist in protecting the agency against litigation; and improve the function of the facility or agency at all levels.”² The ACA publishes standards manuals for 22 areas of corrections practice, including adult correctional institutions, local detention facilities, and juvenile correctional facilities among others.³ If a facility or program seeks accreditation from the ACA, the applicable standards are used to guide that process.

Accreditation is an optional process, but the standards are often cited by state correction agencies as sources and guides for their own specific department and facility policies and practices. According to the ACA, the standards “are designed to facilitate the development of independent agency policy and procedure that govern the agency’s everyday operations.”⁴ As of

¹ “Vision Statement,” American Correctional Association, adopted Aug. 7, 2002, available from www.aca.org/aca_prod_imis/docs/aca_visionstatement.pdf, last accessed Sept. 5, 2017.

² “Welcome to the Standards and Accreditation Department,” American Correctional Association, available from www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_Accreditation/ACA_Member/Standards_and_Accreditation/SAC.aspx?hkey=7f4cf7bf-2b27-4a6b-b124-36e5bd90b93d, last accessed Sept. 5, 2017.

³ “Standards,” American Correctional Association, available from: www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/StandardsInfo_Home.aspx?hkey=7c1b31e5-95cf-4bde-b400-8b5bb32a2bad, last accessed Sept. 20, 2017.

⁴ “What are ACA’s Standards?” American Correctional Association, available from: http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/StandardsInfo_Home.aspx?hkey=7c1b31e5-95cf-4bde-b400-8b5bb32a2bad, last accessed Sept. 20, 2017.

September 5, 2017, the Crossroads Correctional Center operated by CoreCivic in Shelby is accredited by the ACA as an adult correctional institution.⁵

Standards for Adult Correctional Institutions

The most recent standards for adult prisons are contained in two manuals: the *Standards for Adult Correctional Institutions, 4th Edition*, published in 2003, and the *2016 Standards Supplement*. This paper generally refers to standards in those publications as the “ACI standards” and refers to a specific manual when necessary to cite a specific standard.

The ACI standards cover a wide range of topics related to the administration and operation of an adult prison. While not all of the standards specifically relate to restricted housing practices, neither are all of the standards that affect restricted housing practices and conditions contained in one section. Standards that guide inmate discipline, classification, inmate rights, and provision of health care can also play a role in the processes used to make housing decisions, the conditions that are present in a restricted housing unit, and services and treatment provided to offenders.

However, Section D of the ACI standards contains the standards for special management, which includes inmates placed in segregation. The ACI standards use the term “segregation” to include administrative segregation, protective custody, and disciplinary detention, all of which are defined terms used in the standards. Section D is organized around the following principle: “Inmates who threaten the secure and orderly management of the institution may be removed from the general population and placed in special units.”⁶

The first two standards set out general policy and practice for segregation units, including that:

- when a segregation unit exists in a facility, written policy and procedure govern the operation of the unit; and
- immediate segregation can be ordered by certain officials when it is necessary to protect the inmate or others. An order of immediate supervision is reviewed by an appropriate authority within a set number of hours.⁷

Other special management topics covered in the ACI standards in Section D are:

- Admission and Review of Status;
- Supervision;
- General Conditions of Confinement;
- Programs and Services;
- Access to Legal and Reading Materials;
- Exercise Outside of Cell;
- Telephone Privileges; and
- Administrative Segregation/Protective Custody.⁸

In addition, one standard in Section E (Health Care standards) describes when and how health care should be provided to an offender transferred to a segregation unit. Specifically, that standard provides that health care personnel will be informed

⁵ “Search Accredited ACA Facilities,” American Correctional Association, available from:

www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_and_Accreditation/SAC_AccFacHome.aspx?WebsiteKey=139f6b09-e150-4c56-9c66-284b92f21e51&hkey=f53cf206-2285-490e-98b7-66b5ecf4927a&CCO=2#CCO, last accessed Sept. 5, 2017.

⁶ “Section D: Special Management,” *Adult Correctional Institutions, Fourth Edition*, American Correctional Association, 2003, p. 69.

⁷ “ACI Standard 4-4249 and 4-4250,” *Adult Correctional Institutions, Fourth Edition*, p. 69.

⁸ “Section D: Special Management,” *Adult Correctional Institutions, Fourth Edition*, pages 69-74 and “Adult Correctional Institutions (ACI), 4th Edition,” *2016 Supplement*, American Correctional Institution, 2016, pages 69-71.

immediately of the transfer and will assess and review as required by the health unit's protocols. The standard also provides that offenders in the unit will be visited at least daily by a health care provider unless more frequent attention is required.⁹

The Montana Legislative Library has a copy of each of the two manuals that form the ACI standards. The standards are not available online.

Restrictive Housing Standards

As of August 2016, the ACA also provides a set of proposed performance-based standards specific to restrictive housing. Performance-based standards are being developed in all corrections topic areas and revise the elements that combine to form an ACA standard.¹⁰ While in the past a standard contained a statement of the standard and a comment, the performance-based standards include six elements, including a statement of the standard and a comment. The new additions are outcome measures, expected practices, protocols, and process indicators. Under performance-based standards, a key relationship is between a standard and an expected practice. A performance-based standard is “a statement that clearly defines a required or essential *condition* to be achieved and maintained.”¹¹ The expected practices are “actions and activities that, if implemented properly (according to protocols), will produce the desired outcome.”¹²

While the ACA doesn't expect the new performance-based standards to be revised as much as the previous standards, it does anticipate that the expected outcomes will be revised as agencies implement the standards, collect data and assess outcomes, and learn from their experiences.¹³ The ACA expects that the performance-based standards model will allow corrections agencies to “collect, track, and analyze internal outcomes related to each standard in order to gage their performance and adjust their operations accordingly.”¹⁴

In the performance-based standards, restrictive housing is defined as “a placement that requires an inmate to be confined to a cell at least 22 hours per day for the safe and secure operation of the facility.”¹⁵ There are 35 proposed standards and a definitions section. The majority of the performance-based standards have cross-references to existing ACI standards. Highlights of the sections without a cross-reference include the following:

- An agency's policies, procedures, and practices limit the placement of an inmate in restricted housing to circumstances “that pose a direct threat to the safety of persons or a clear threat to the safe and secure operations of the facility” (4-RH-0001).¹⁶
- An agency's policies, procedures, and practices attempt to ensure an offender is not released directly to the community from restricted housing (4-RH-0030).
- The agency will not place a person with a serious mental illness into extended restrictive housing (4-RH-0031). The standards consider isolating an offender from the general population and restricting the offender to a cell for at least 22 hours a day for more than 30 days to be extended restrictive housing. The definition of serious mental illness

⁹ ACI Standard 4-4400,” *Adult Correctional Institutions, Fourth Edition*, American Correctional Association, 2003, p. 122.

¹⁰ “Performance-Based Standards Explained,” *Adult Correctional Institutions, Fourth Edition*, American Correctional Association, 2003, p. xxii.

¹¹ “Performance-Based Standards Explained,” *Adult Correctional Institutions, Fourth Edition*, p. xxiii.

¹² “Performance-Based Standards Explained,” *Adult Correctional Institutions, Fourth Edition*, p. xxiv.

¹³ “Performance-Based Standards Explained,” *Adult Correctional Institutions, Fourth Edition*, p. xxvi.

¹⁴ “What are ACA's Standards?” American Correctional Association.

¹⁵ “Restrictive Housing Performance Based Standards,” American Correctional Association, August 2016, p. 3, available from: http://www.aca.org/ACA_Prod_IMIS/ACA_Member/Standards_Accreditation/Standards/Restrictive_Housing_Committee/Restrictive_Housing_Committee/Restrictive_Housing_Committee.aspx?hkey=458418a3-8c6c-48bb-93e2-b1fcbca482a2, last accessed Sept. 20, 2017 [Will be cited as “Restrictive Housing Performance Based Standards,” American Correctional Association].

¹⁶ “Restrictive Housing Performance Based Standards,” American Correctional Association, p. 6,

includes psychotic disorders, bipolar disorders, and major depressive disorder, along with “any diagnosed mental disorder ... currently associated with serious impairment in psychological, cognitive, or behavioral functioning that substantially interferes with the person’s ability to meet the ordinary demands of living and requires an individualized treatment plan by a qualified mental health professional(s).”¹⁷

- An agency’s policies, procedures, and practices offer “step down programs” that meet specified basic standards to assist inmates in returning to either the prison general population or the community (4-RH-0032).
- Pregnant inmates will not be placed in extended restrictive housing (4-RH-0033).
- Placing inmates under 18 years of age in extended restrictive housing is prohibited (4-RH-0034).
- An inmate will not be placed in restrictive housing solely on the basis of gender identity (4-RH-0035).

The other standards cover topics similar to the ACI standards: how inmates are placed in and removed from restricted housing, living conditions in restricted housing, access to services and programs, visits from correctional and mental health staff, and status reviews of placements.

Association of State Correctional Administrators Policy Guidelines

The Association of State Correctional Administrators (ASCA) is composed of leaders of the state correctional agencies and also includes similar officials from several cities, U.S. territories, the District of Columbia, and the U.S. Bureau of Prisons. The association’s goal is to “to increase public safety by utilizing correctional best practices, accountability, and providing opportunities for people to change.”¹⁸ ASCA has established two sets of guiding principles that relate to the SJ 25 study of solitary confinement: one on restrictive housing specifically and the other on the treatment of the incarcerated mentally ill.

Guiding Principles for Restrictive Housing Status

In 2013, a subcommittee established by ASCA released a set of guiding principles related to restrictive housing practices. The principles are not required of member agencies but “are recommended for consideration by correctional agencies for inclusion in agency policy.”¹⁹ ASCA defines restrictive housing as “a form of housing for inmates whose continued presence in the general population would pose a serious threat to life, property, self, staff or other inmates, or to the security or orderly operation of a correctional facility. This definition does not include protective custody.”²⁰ The 13 guidelines include recommendations about:

- processes used to review decisions on when an offender is placed into and removed from restrictive housing, including incentives for positive offender behavior, basing length of stay on threat levels and rule compliance rather than set time periods, and an objective review of an offender’s housing status to inform the continued placement of the offender in restrictive housing;
- mental health reviews and access to medical and mental health staff and services;
- conditions of life in restrictive housing, including opportunities for exercise and visitation, and the ability to maintain proper hygiene;
- transition back to the general population or the community;
- data collection; and

¹⁷ “Restrictive Housing Performance Based Standards,” American Correctional Association, Aug. 2016, p. 3.

¹⁸ ASCA website, available at www.asca.net, last accessed Sept. 5, 2017.

¹⁹ “Restrictive Status Housing Policy Guidelines,” Association of State Correctional Administrators, Aug. 9, 2013, page 2, available at <http://www.asca.net/pdfdocs/9.pdf>, last accessed Sept. 5, 2017.

²⁰ “Restrictive Status Housing Policy Guidelines,” Association of State Correctional Administrators, Aug. 9, 2013, page 1.

- staff training specific to restrictive housing.

A complete list of the guiding principles is available in Appendix A of this report or online at www.asca.net/pdfdocs/9.pdf.

Guiding Principles for the Treatment of the Incarcerated Mentally Ill

Another set of guiding principles developed by an ASCA subcommittee relates to treatment of individuals with a mental illness who are incarcerated. Although the guiding principles document itself is undated, the version of the principles used in this report was uploaded to the ASCA website at the end of August 2017.²¹ The principles provide guidance in 16 different categories including assessment, individualized treatment planning, coordination of services and providers, reentry planning, incentive-based programs, and data-driven programs and practices.

The principles include one specific to restrictive housing: “Use restrictive housing only as a last resort and follow the ASCA’s Resolution 24 Restrictive Housing Guiding Principles.”²²

A complete list of the guiding principles is available in Appendix B of this report or online at www.asca.net/pdfdocs/24.pdf.

U.S. Department of Justice

In January 2016, the U.S. Department of Justice (U.S. DOJ) issued a final report on its study of restrictive housing, which it undertook at the request of then President Obama. The study request directed that the U.S. DOJ examine the background and current use of restricted housing as well as “develop strategies for reducing the use” of restricted housing. The report uses the terms “restrictive housing” and “segregation,” which are defined as “detention that involves three basic elements: removal from the general population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.”²³

The report noted the importance of the issue in terms of its impact on not only inmates but also correctional staff. It concluded that, at times, “correctional officials have no choice but to segregate inmates from the general population, typically when it is the only way to ensure the safety of inmates, staff, and the public and the orderly operation of the facility” but that restrictive housing “should be used rarely, applied fairly, and subjected to reasonable constraints.”²⁴

Guiding Principles for All Correctional Systems

The U.S. DOJ report also includes “guiding principles,” which the authors intend to be “best practices” for prisons in U.S. jurisdictions. Understanding that not all of the principles could be implemented immediately or without collaboration with correctional staff and officers,²⁵ the report’s executive summary describes the principles as “aspirational principles...designed to serve as a roadmap for correctional systems seeking direction on future reforms.”²⁶ There are 50 principles that cover topics

²¹ “Guiding Principles for the Treatment of the Incarcerated Mentally Ill,” Association of State Correctional Administrators, Aug. 30, 2017, available at www.asca.net/pdfdocs/24.pdf, last accessed Sept. 5, 2017.

²² “Guiding Principles for the Treatment of the Incarcerated Mentally Ill,” Association of State Correctional Administrators.

²³ “Report and Recommendations Concerning the Use of Restrictive Housing,” U.S. Department of Justice, Jan. 2016, p. 3, available at: www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing, last accessed Sept. 8, 2017 [Will be cited as U.S. DOJ Final Report].

²⁴ U.S. DOJ Final Report, p. 1.

²⁵ U.S. DOJ Final Report, p. 2.

²⁶ “Executive Summary of the Report and Recommendations Concerning the Use of Restrictive Housing,” U.S. Department of Justice, Jan. 2016, p. 2, available at: www.justice.gov/archives/dag/report-and-recommendations-concerning-use-restrictive-housing, last accessed Sept. 8, 2017 [Will be cited as U.S. DOJ Executive Summary].

from how and when inmates should be placed in restrictive housing, the conditions of that housing, staff training, how and when an inmate should be returned to the general population or to the community, treatment of inmates with a mental illness or who are juveniles or pregnant, and data collection.

The report's summary of the principles provided in the executive summary follows. The full list of principles is available online at www.justice.gov/archives/dag/file/815556/download.

“This Report’s ‘Guiding Principles’ include:

- Inmates should be housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff, other inmates, and the public.
- Correctional systems should always be able to clearly articulate the specific reason(s) for an inmate’s placement and retention in restrictive housing. The reason(s) should be supported by objective evidence. Inmates should remain in restrictive housing for no longer than necessary to address the specific reason(s) for placement.
- Restrictive housing should always serve a specific penological purpose.
- An inmate’s initial and ongoing placement in restrictive housing should be regularly reviewed by a multi-disciplinary staff committee, which should include not only the leadership of the institution where the inmate is housed, but also medical and mental health professionals.
- For every inmate in restrictive housing, correctional staff should develop a clear plan for returning the inmate to less restrictive conditions as promptly as possible. This plan should be shared with the inmate, unless doing so would jeopardize the safety of the inmate, staff, other inmates, or the public.
- All correctional staff should be regularly trained on restrictive housing policies. Correctional systems should ensure that compliance with restrictive housing policies is reflected in employee-evaluation systems.
- Correctional systems should establish standing committees, consisting of high-level correctional officials, to regularly evaluate existing restrictive housing policies and develop safe and effective alternatives to restrictive housing.
- Absent a compelling reason, prison inmates should not be released directly from restrictive housing to the community.
- Correctional systems should seek ways to increase the minimum amount of time that inmates in restrictive housing spend outside their cells and to offer enhanced in-cell opportunities. Out-of-cell time should include opportunities for recreation, education, clinically appropriate treatment therapies, skill-building, and social interaction with staff and other inmates.”²⁷

National Commission on Correctional Health Care

The National Commission on Correctional Health Care (NCCHC) is a national nonprofit organization whose mission is to “improve the quality of health care in jails, prisons, and juvenile confinement facilities.”²⁸ To that end, the NCCHC provides accreditation and certification programs, education programs, research, and technical assistance to correctional facilities. In July 2014, the NCCHC re-accredited the infirmary at the Montana State Prison for 3 years. The infirmary was initially accredited in 2011²⁹ and is currently undergoing the process to be re-accredited for an additional 3 years.

²⁷ U.S. DOJ Executive Summary, p. 3 [bold highlighting in the original report removed].

²⁸ National Commission on Correctional Health Care website, available at: www.ncchc.org, last accessed Sept. 5, 2017.

²⁹ “Montana State Prison Health Services Ace National Re-accreditation Review,” press release, Montana Department of Corrections, July 29, 2014, available at: <https://cor.mt.gov/Portals/104/news/MSPInfirmaryReaccreditation.pdf>, last accessed Sept. 5, 2017.

Position Statement on Solitary Confinement (Isolation)

The NCCHC adopted a position statement on solitary confinement in April 2016. The statement defines solitary confinement as “the housing of an adult or juvenile with minimal to rare meaningful contact with other individuals.”³⁰ (This definition is also used in the preamble of the SJ 25 study resolution.) The NCCHC definition also includes that individuals in solitary confinement “often experience sensory deprivation and are offered few or no educational, vocational, or rehabilitative programs” and notes that correctional jurisdictions use a variety of terms to refer to the practice.³¹ The purpose of the position statement is to “assist health care professionals in addressing the use of solitary confinement in the facilities in which they work.”³²

After providing background and outlining various research into the effects of solitary confinement, the position statement reviews international standards related to the practice. In total, the NCCHC provides 17 principles as guidance for correctional health professionals. The principles include the duties of correctional health professionals to their patients, when and for what purposes solitary confinement should be used, how and when health staff should be involved with patients such as initial evaluations upon an individual’s placement in isolation, the availability of reentry programs, and the conditions of confinement that should exist when an inmate is placed in isolation. Specifically, the principles include that solitary confinement should not exceed 15 days and that juveniles, mentally ill individuals, and pregnant women should be excluded from the practice.³³

A full list of the principles is available in Appendix C of this report or online at www.ncchc.org/solitary-confinement.

³⁰ “Solitary Confinement (Isolation),” position statement, National Commission on Correctional Health Care, April 2016, available from: www.ncchc.org/solitary-confinement, last accessed Sept. 5, 2017 [Will be cited as “Solitary Confinement (Isolation),” National Commission on Correctional Health Care].

³¹ “Solitary Confinement (Isolation),” National Commission on Correctional Health Care.

³² “Solitary Confinement (Isolation),” National Commission on Correctional Health Care.

³³ “Solitary Confinement (Isolation),” National Commission on Correctional Health Care, guidelines 1, 2, and 5.

APPENDIX A: RESTRICTIVE HOUSING POLICY GUIDELINES, ASCA

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Restrictive Status Housing Policy Guidelines

Purpose

The Association of State Correctional Administrators [ASCA] recognizes the importance and challenges associated with managing inmates who pose a serious threat to staff, other inmates or to the safe and orderly operation of correctional facilities. The use of restrictive housing is a necessary tool for correctional systems to utilize to ensure a safe environment for staff and inmates. ASCA is committed to the universal classification principle of managing inmates in the least restrictive way necessary to carry out its mission.

As a result, ASCA established a sub-committee for the purpose of creating guiding principles that might be used by member agencies for the purpose of developing policies related to restrictive status housing. ASCA recognizes that individual jurisdictions have specific issues, unique legislation, judicial orders, and varying physical plant configurations that must be considered locally and addressed by policies specific to those individual jurisdictions. Based on the complexity of managing this population, some universal principles provide this general framework for agencies in the development of their policies. We hope this document is helpful to jurisdictions in designing policies to safely manage this population in a manner that promotes their positive transition to less restrictive settings while supporting an environment where other inmates may safely and actively participate in pro-social programs and activities.

Defining Restrictive Housing

Restrictive status housing is a term used by correctional professionals to encompass a larger number of agency specific nomenclatures. In general terms, restrictive status housing is a form of housing for inmates whose continued presence in the general population would pose a serious threat to life, property, self, staff or other inmates, or to the security or orderly operation of a correctional facility. This definition does not include protective custody. Restrictive status housing is designed to support a safe and productive environment for facility staff and inmates assigned to general population as well as to create a path for those inmates in this status to successfully transition to a less restrictive setting.

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Guiding Principles for Restrictive Status Housing

The following guiding principles for the operation of restrictive status housing are recommended for consideration by correctional agencies for inclusion in agency policy. They are to:

1. Provide a process, a separate review for decisions to place an offender in restrictive status housing;
2. Provide periodic classification reviews of offenders in restrictive status housing every 180 days or less;
3. Provide in-person mental health assessments, by trained personnel within 72 hours of an offender being placed in restrictive status housing and periodic mental health assessments thereafter including an appropriate mental health treatment plan;
4. Provide structured and progressive levels that include increased privileges as an incentive for positive behavior and/or program participation;
5. Determine an offender's length of stay in restrictive status housing on the nature and level of threat to the safe and orderly operation of general population as well as program participation, rule compliance and the recommendation of the person[s] assigned to conduct the classification review as opposed to strictly held time periods;
6. Provide appropriate access to medical and mental health staff and services;
7. Provide access to visiting opportunities;
8. Provide appropriate exercise opportunities;
9. Provide the ability to maintain proper hygiene;
10. Provide program opportunities appropriate to support transition back to a general population setting or to the community;
11. Collect sufficient data to assess the effectiveness of implementation of these guiding principles;
12. Conduct an objective review of all offenders in restrictive status housing by persons independent of the placement authority to determine the offenders' need for continued placement in restrictive status housing; and
13. Require all staff assigned to work in restrictive status housing units receive appropriate training in managing offenders on restrictive status housing status.

APPENDIX B: GUIDING PRINCIPLES FOR THE TREATMENT OF THE INCARCERATED MENTALLY ILL, ASCA

Guiding Principles for the Treatment of the Incarcerated Mentally III

Purpose

The Association of State Correctional Administrators (ASCA) recognizes the importance of and challenges associated with managing incarcerated individuals with mental illness. We also understand that Corrections is the largest provider of mental health services in the United States, and with that, comes the responsibility to balance treatment with the safety of staff and inmates.

As a result, ASCA established a sub-committee to create guiding principles for member agencies to assist them in developing policies and practices related to the treatment and safety of individuals with mental illness. ASCA recognizes that each jurisdiction has specific issues, varying physical plant configurations, and may have unique legislation and judicial orders that must be considered locally and addressed by policies specific to each individual jurisdiction. Regardless of those differences, ASCA believes that our approach should be designed to support a safe and productive environment for facility staff; the treatment and safety of those individuals in our care who have mental illness; and a continuum of care as these individuals return to society.

Guiding Principles

Support - Promote commitment to the wellbeing of individuals with mental illness in our care, with consistent emphasis on support, patience, empathy, encouragement, treatment and safety.

Accountability - Be accountable for those individuals with mental illness, and ensure their continuous receipt of individualized, quality treatment, services and programming.

Empowerment - Empower and motivate incarcerated individuals with mental illness to participate in their own treatment planning, emphasize personal responsibility, encourage self-care and self-direction, and when appropriate, use peer support specialists.

Assessment - Perform standardized assessment by qualified mental health professionals of all individuals with mental illness at the time of reception, at regular intervals, thereafter, and following triggering events, using appropriately trained behavioral health professionals. Assign functionality codes to help staff respond appropriately to offenders with varying degrees of mental illness severity.

Individualized Treatment Planning - Develop behavioral health treatment plans by a multidisciplinary treatment team that are individualized, reviewed and revised as needed and have clear and measurable outcomes. The treatment plan is based on mental health, substance abuse and risk assessments evaluations, while incorporating individual strengths, needs, experiences, gender responsiveness, cultural background and trauma history.

Access to Services - Ensure that individuals with mental illness have access to evidence-based programs and services that include educational, counseling, medical, behavioral health and social services; as well as commissary, library services, recreational programs, religious guidance, and telephone access.

Coordination of Services and Providers - Ensure that each facility has a behavioral health director to coordinate treatment services for designated individuals, track behavioral health outcomes, and provide a comprehensive plan for a continuum of care.

Incentive-Based Settings and Programs - Include evidence-based incentives that promote positive behavior and adjustment for those with mental illness.

Restrictive Housing - Use restrictive housing only as a last resort and follow the ASCA's Resolution 24 Restrictive Housing Guiding Principles.

Data-Driven Programs and Practices - Implement programs and practices that match the needs of the populations with mental illness, monitor for quality and fidelity, and collect data to measure outcomes.

Education and Training - Train all staff involved with the care and custody of mentally ill individuals on crisis intervention and behavioral health intervention, and how to recognize the signs of mental illness and effectively deliver programs to individuals with mental illness, and make appropriate referrals for treatment.

Resource Specialization - Ensure that behavioral health housing units are treatment and support oriented and are staffed by those with targeted training in behavioral health issues. Implement programs and determine other resources based on the specific needs of individuals with mental illness, physical structure of facilities, and other service requirements.

Suicide Prevention - Maintain a multidisciplinary committee at each facility to stay current on suicide prevention research, make ongoing recommendations for improvement, and review all attempted and completed suicides and other self-injurious behaviors. Train staff on current suicide prevention research, assessment tools, screening, monitoring, and appropriate housing and treatment strategies to help individuals at risk of hurting themselves or others.

Quality Improvement Reviews - Perform periodic, cross-departmental reviews of behavioral health services, treatment, safety and security to evaluate quality and provide oversight for necessary areas of improvement.

Reentry Planning - Plan for the continuity of care for individuals with mental illness as part of reentry programming. Ensure individuals with mental illness receive access to pre-release continuity of care planning that provides the resources necessary for post-release access of mental health treatment in their communities.

Communication After Release - For those agencies that have the responsibility for supervision after release, ensure a clear and effective line of communication exists between the correctional facility and the community supervision entity. Encourage information sharing with community-based behavioral health providers post-release.

APPENDIX C: SOLITARY CONFINEMENT (ISOLATION) POSITION STATEMENT, NCCHC

POSITION STATEMENT

The following principles are to guide correctional health professionals in addressing issues about solitary confinement.

1. Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health.
2. Juveniles²⁸, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration.
3. Correctional health professionals should not condone or participate in cruel, inhumane, or degrading treatment of adults or juveniles in custody.
4. Prolonged solitary confinement should be eliminated as a means of punishment.
5. Solitary confinement as an administrative method of maintaining security should be used only as an exceptional measure when other, less restrictive options are not available, and then for the shortest time possible. Solitary confinement should never exceed 15 days. In those rare cases where longer isolation is required to protect the safety of staff and/or other inmates, more humane conditions of confinement need to be utilized.
6. Correctional health professionals' duty is the clinical care, physical safety, and psychological wellness of their patients.
7. Isolation for clinical or therapeutic purposes should be allowed only upon the order of a health care professional and for the shortest duration and under the least restrictive conditions possible, and should take place in a clinically designated and supervised area.
8. Individuals who are separated from the general population for their own protection should be housed in the least restrictive conditions possible.
9. Health staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation.
10. Individuals in solitary confinement, like other inmates, are entitled to health care that is consistent with the community standard of care.
11. Health care staff should evaluate individuals in solitary confinement upon placement and thereafter, on at least a daily basis. They should provide them with prompt medical assistance and treatment as required.
12. Health care staff must advocate so that individuals are removed from solitary confinement if their medical or mental health deteriorates or if necessary services cannot be provided.
13. Principles of respect and medical confidentiality must be observed for patients who are in solitary confinement. Medical examinations should occur in clinical areas where privacy can be ensured. Patients should be examined without restraints and without the presence of custody staff unless there is a high risk of violence. In situations where this cannot occur, the patient's privacy, dignity, and confidentiality should be maintained as much as possible. If custody staff must be present, they should maintain visual contact, but remain at a distance that provides auditory privacy.
14. Health care staff should ensure that the hygiene and cleanliness of individuals in solitary confinement and their housing areas are maintained; that they are receiving sufficient food, water, clothing, and exercise; and that the heating, lighting, and ventilation are adequate.
15. Adults and juveniles in solitary confinement should have as much human contact as possible with people from outside the facility and with custodial, educational, religious, and medical staff.

16. Appropriate programs need to be available to individuals in confinement to assist them with the transition to other housing units or the community, if released from isolation to the community.
17. In systems that do not conform to international standards, health care staff should advocate with correctional officials to establish policies prohibiting the use of solitary confinement for juveniles and mentally ill individuals, and limiting its use to less than 15 days for all others.

**Adopted by the National Commission on Correctional Health Care Board of Directors
April 10, 2016**

NOTES

1. Shames, A., Wilcox, J., & Subramanian, R. (May 2015). **Solitary confinement: Common misconceptions and emerging safe alternatives**. Vera Institute of Justice.
2. See, e.g., Madrid, 889 F. Supp. at 1265-66; Ruiz v. Johnson, 37 F.Supp.2d 855, 915 (S.D. Tex. 1999), 243 F.3d 941 (5th Cir. 2001), adhered to on remand, 154 F.Supp.2d 975 (S.D. Tex. 2001).
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