

ERADICATING THE USE OF SAFE CELLS

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Abstract

This memo is addressed to the D.C. Justice Lab. Solitary confinement, defined as isolation from human contact for 22-24 hours per day, can lead to various negative physical and psychological effects (Solitary Confinement, 2018). It is the District of Columbia Department of Corrections' (DOC) policy to place people in custody who are at high risk of suicide in a "safe cell", which is a form of solitary confinement. The D.C. DOC should end this policy because it does not meet best practices; the conditions of solitary confinement in safe cells are inhumane and exacerbate peoples' mental health needs. This report recommends that the DOC transfer people who are at high risk of suicide to external medical or mental health facilities.

Background

Solitary Confinement:

Solitary confinement is defined as isolation from human contact for 22-24 hours a day (Solitary Confinement, 2018). Quaker leaders like Benjamin Franklin were the first to institute solitary confinement in the late 18th century at the Walnut Street Jail in Philadelphia. Their rationale was that isolation and silence would result in penitence. The Southeastern Pennsylvania Penitentiary, built in 1829, was composed of only solitary cells (National Religious Campaign Against Torture, n.d.). Forms of solitary confinement include disciplinary isolation, punitive segregation, administrative segregation and restrictive housing, involuntary protective custody, and safe cells. The definition or application of these practices depend upon the jurisdiction but are similar in definition and/or practice (Solitary Confinement, 2018).

According to Solitary Watch, a national nonprofit that studies solitary confinement in the United States, "disciplinary" or "punitive segregation" refers to solitary confinement assigned for violating any prison rules. This isolation can last from days to years in some jails and prisons. Isolation for the cause of promoting safety of correctional officers or other prison inmates is "administrative segregation," which differs from "involuntary protective confinement" in that the latter is specifically for vulnerable populations such as children held in adult prisons and LGBTQ+ individuals. People who are imprisoned can be placed in this type of solitary confinement for months to years in some facilities. "Involuntary protective confinement". This type of solitary confinement was formed with the intent for their own safety (Solitary Confinement, 2018). The use of "safe cells" is a form of solitary confinement to protect inmates with mental health needs or who are at risk of self-harm (Ryals, 2021).

Solitary confinement has several unintended consequences, ranging from negative physical and psychological effects to increased administrative and operational costs. Solitary confinement is associated with higher mortality rates after release. Being in solitary confinement is a social determinant of poor health outcomes for the incarcerated individual upon release. Lastly, there are increased costs for medical/mental health for someone held in solitary (Solitary Confinement - a Public Health Crisis, 2021). For these reasons solitary confinement is ineffective and counterproductive.

Safe cells are intended to protect an inmate who is experiencing a mental health crisis. However, this practice is inhumane and has the potential to exacerbate a mental health crisis. There are various alternatives to this approach that better supports people with mental health needs who are at risk of self-harm.

D.C. Correctional Facilities:

There are two correctional facilities operated by the D.C. Department of Corrections that use safe cells, including the Central Detention Facility (CDF), also known as the D.C. Jail, which has the capacity to hold 2,164 people in custody and only houses men. The second is the Correctional Treatment Facility (CTF), which has the capacity to hold 1,400 people in custody and houses both men and women (District of Columbia Corrections Information Council [CIC], 2019). The CDF includes six safe cells within the Acute Care Mental Health Unit, which is designed for people who are at risk of self-harm and in the medical unit (District of Columbia Department of Corrections [DOC], 2017; CIC, 2019). In CTF, there are two safe cells in the women's mental

health unit, which houses women with mental health needs, and three in the Medical 82 unit, which houses people with acute medical needs (CIC, 2019).

In 2021, the average daily population in CDF was 1,000 and 413 in CTF, for a total average of 1,413 (DOC, 2021). This includes 1,360 men across CDF and CTF, and 53 women housed in CTF (DOC, 2021). As of June 2021, the average length of stay (ALOS) was 363.8 days for men and 217.6 days for women (DOC, 2021). However, the average length of stay metric has been skewed largely due to policies during the COVID-19 pandemic, as the ALOS is typically much shorter (for example, 44 days for women and 79 days for men in fiscal year 2018) (CIC, 2019). The recidivism rate in D.C. correctional facilities in 2020, defined as more than one booking within the calendar year, was 15.7% (DOC, 2021).

Inmates held in custody in D.C. are disproportionately Black, representing 82.8% of the population in correctional facilities but only 46% of the local population (DOC, 2021). People who are white and Hispanic represent 9.4% and 6.3% of the population in custody in D.C., respectively (DOC, 2021). The median age of people held in custody is 32.2 years old. 69.4% of men and 62.5% of women are between the ages of 21 and 40 (DOC, 2021). The majority (53.1% of women and 64.5% of men) reside in DC and Maryland (20.3% of women and 18.0% of men), and 8.6% indicate that they are homeless (DOC, 2021).

Mental Health Needs of People in D.C. DOC Custody:

In fiscal year (FY) 2020 and 2021, an estimated 40.6% of people housed in the jail per month had an active, confirmed mental health diagnosis (Council of the District of Columbia, 2021). The rate of people at intake into D.C. DOC custody with a diagnosed mental illness more than quadrupled from FY 2018 to FY 2020, growing from 12.9% to 52.6% (Government of the District of Columbia, 2021; DOC, 2021). This population is more likely to be held in custody longer, as the ALOS for people with serious mental illness (SMI) in CDF or CTF is estimated to be three times longer than that of the population without a diagnosis (District Task Force on Jails & Justice, 2019). People with mental health needs – and especially those with SMI – are more likely to experience a mental health crisis (Substance Abuse and Mental Health Services Administration, 2009).

While the mentally ill population in D.C. DOC custody has increased, the availability of mental health services has increased at the same rate. The Mental Health Step Down Unit provides mental health services for people who experienced a crisis but did not require acute services. From FY 2018 to FY 2020, the number of people housed in, decreased by 16.9% (Government of the District of Columbia, 2021). Similarly, the number of people housed in the Acute Mental Health Unit decreased by 26.8% from FY 2018 to 2020 (Government of the District of Columbia, 2021). Additionally, while the D.C. DOC provides the majority of health services through a contract with Unity Health Care (UHC), D.C. DOC direct spending on health services was 29.2% lower in FY 2020 than in FY 2016 (Government of the District of Columbia, 2021; Government of the District of Columbia, 2018).

Rationale For Eradicating Safe Cells in D.C.

The D.C. DOC defines a safe cell as one that: “provides visibility of inmates and is designed to be suicide resistant by being free of physical structure that could be used in a suicide attempt (e.g. electrical switches or outlets, bunks with open bottoms, towel racks on desks and sinks, radiator vents, or any other fixtures which could be used as anchoring devices for hanging or areas used to jump off of)” (DOC, 2017, pp. 5).

According to D.C. DOC’s Suicide Prevention and Intervention policy, 6080.2G, at intake and upon staff referral, medical or mental health professionals from UHC, the contracted health provider, administer a mental health screening and assessment to people housed in CDF or CTF (DOC, 2017). Based on the results, the providers can assign inmates to the general population with or without referral to mental health care, a mental health unit, a safe cell for those on suicide precautions or suicide watch, or referring them to emergency treatment (DOC, 2017). For those in safe cells, mental health staff develop treatment plans and conduct daily evaluation checks to update the plans (CIC, 2019).

There are three primary reasons that the D.C. DOC should eradicate the use of safe cells:

1. The current D.C. DOC policy does not meet best practices.
2. Conditions in safe cells are inhumane; and
3. Safe cells exacerbate mental health needs.

Current D.C. DOC Policy Does Not Meet Best Practices:

The use of safe cells in correctional facilities is contradictory to the D.C. DOC's own standard operating procedures, which asserts that people held in solitary confinement are at increased risk of suicide (DOC, 2017). The policy also states that mental health services that are provided must align with the National Commission on Correctional Health Care (NCCHC) Standards (DOC, 2017). The NCCHC's *Standards for Mental Health Services in Correctional Facilities* (2015) declares, "facilities that provide for patients who require psychiatric hospitalization levels of care are expected to mirror treatment provided in community inpatient settings" (NCCHC, 2010). If a correctional facility is inadequately staffed with mental health professionals to provide such services, the agency should have a formal arrangement with community-based behavioral health providers who can provide emergency mental health care (Mental Health America, 2020). These standards are not being adhered to through the utilization and operation of safe cells. Additionally, secluding people with mental health needs in safe cells challenges the Eighth Amendment, the Americans with Disabilities Act, and *Olmstead v. L.C.* (Takshi, 2020).

Through its contract, UHC is paid a fixed rate per person per day by D.C. DOC to provide health and behavioral health services to people held in custody (Office of Contracting and Procurement, 2019). Given this fixed rate and the range of medical and behavioral health needs across the population in custody, UHC lacks the incentive to provide the level of treatment and services required to adequately meet the high level of need of people in safe cells. Reports suggest that mental health staff do not conduct evaluations daily as required, these evaluations are not a formalized mental health assessment, and they typically last less than one minute (CIC, 2019; Smith, 2020). Initial treatment plans are developed by UHC doctors but executed by DOC staff; this creates tension and results in the repeated loss of privileges for occupants (Smith, 2020). Additionally, staff may be less likely to transport people experiencing an acute mental health crisis to an external psychiatric setting that would better meet their needs because UHC is financially responsible for all ambulance costs, non-hospital transportation, and in-patient hospitalizations (Office of Contracting and Procurement, 2019).

Other jurisdictions have passed comprehensive bills restricting the use of solitary confinement, particularly for vulnerable populations such as people with mental illnesses and creating alternative rehabilitative and therapeutic confinement options. Dozens of states have introduced legislation to ban or restrict solitary confinement (Fettig, 2019). The HALT Act in New York (NY State Senate Bill S2836), the Isolated Confinement Restriction Act in New Jersey (A314/S3261), and the Legislative Bill 686 in Nebraska are among the more prominent pieces of legislation that have passed.

Conditions in Safe Cells are Inhumane:

Given the range of negative impacts of solitary confinement, the use and conditions of safe cells in D.C. have been criticized for nearly a decade. Notably, a 2013 report from the National Institute of Corrections and a 2015 report from the Washington Lawyers' Committee described D.C. DOC's suicide prevention practices and provided recommendations for improvement, including avoiding isolation, as well as the removal of clothing and cancellation of privileges, such as phone calls, visitation, and recreation, except as a last resort (Hayes, 2013; Washington Lawyers' Committee, 2015; Ryals, 2021). While D.C. DOC reported that it had implemented these recommendations as of 2015, evidence from a 2016 court case documented the continuing inhumane conditions inside safe cells (DOC, 2015; Ryals, 2021). Occupants described conditions of forced nudity with only a velcroed smock, freezing temperatures, sleeping on a hard plastic box with no mattress or blanket, a toilet and sink but no running water (and therefore no ability to flush the toilet or wash one's hands), fluorescent lighting left on 24 hours a day, the smell of feces, and no access to showers, visitation, phone calls, personal conversations with other jail residents or officers, or food other than "finger foods" (Ryals, 2021).

In response, the D.C. DOC updated its suicide prevention and intervention policy in 2017 to include several protections for people held in safe cells. According to D.C. DOC policy, when placed in a safe cell, people are strip-searched and:

- Must be provided with “safety clothing,” a “safety mattress,” a “safety blanket,” and safe eating utensils.
- Must be allowed outside of their cells for 30 minutes per day;
- Must have access to running water and dimmed lights, but restrictions are allowed;
- May have access to a shower, socks and shoes, personal property (DOC, 2017).

While these policy revisions were implemented in 2017, there is evidence that staff continue to violate these guidelines. A March 2020 report from University Legal Services notes that based on 34 random checks of safe cells, staff did not allow safe cell occupants time outside of their cell. Treatment plans developed and documented by UHC take into account any restrictions placed upon safe cell occupants including access to showers, running water, and mattresses. These plans are often applied inconsistently, whereby staff may use these plans as a mechanism for retaliation (Smith, 2020; CIC, 2019). Testimony from *Edward Banks, v. Quincy Booth*, an open case filed in March 2020 against the D.C. DOC for their practices during COVID-19, states that at least one individual was held in custody in a safe cell for over a month without any time out of the cell, with lights on at full brightness, and without running water (Banks, 2020).

Safe Cells Exacerbate Mental Health Needs:

Information on the rate of occupancy and impact of safe cells in D.C. is limited, and a Freedom of Information Act request for data has been unsuccessful thus far. Given this limitation, it is unclear how many people have been secluded in safe cells in D.C. However, in 2018, an estimated 1,781 people were held in solitary confinement in D.C. At 36%, the prevalence of active mental illness among this population was more than double that of the general population, and 297 alerts for suicide-related behavior were called for this group (DOC, 2020).

Solitary confinement is particularly detrimental for people with mental health needs, who frequently further decompensate due to extreme stress and social isolation (Metzner & Fellner, 2010). These negative mental health impacts are long-term, with studies indicating effects may persist for at least one year after solitary confinement (Reiter et al, 2020). As in other facilities, people held in D.C. DOC custody likely cycle between solitary confinement and safe cells rather than receiving appropriate mental health treatment and services (Kupers, 2008).

Recommendations

The D.C. DOC can no longer afford to maintain the substandard and inhumane status quo of its safe cells policy as the administrative solution or healthcare approach for the treatment of residents suffering from an acute mental health crisis in the D.C. jail. Individuals who suffer from mental illness are most often the most marginalized and mistreated members of society. They are deprived of support systems, legal counsel, specialized care, and most importantly, human dignity that should be afforded to any and all citizens, free or incarcerated. Within the D.C. jail, inmates cannot afford the D.C. DOC maintains the status quo of safety for those suffering a mental health crisis. To combat this policy failure, we recommend the following solutions for the short, medium, and long term. These recommendations are not only specific to the D.C. Jail. They address public health shortfalls in mental and behavioral health service provisions, which often lead affected persons to incarceration.

Short- & Medium-Term Policy Recommendations:

Incarcerated individuals experiencing a mental health crisis, regardless of the severity, should be transported to external medical facilities for inpatient treatment. There, they should receive appropriate treatment as diagnosed by board certified psychiatrists. This step would mitigate issues present in data that within the prison population detained individuals are subject to stigma, discrimination, and inadequate mental health services. The prison environment elicits detrimental effects on mental health due to overcrowding, violence, enforced solitude, lack of privacy, lack of meaningful activity, and isolation. Prisons do not provide the necessary therapeutic environment for those suffering from mental illness (World Health Organization, 2005).

Implementation of an Internal PRISM Evaluation within the DC Jail (Performance Related Information for Staff and Managers). We recommend implementing the evaluation method already in practice at Saint Elizabeth’s Hospital, operated by the District of Columbia Department of Behavioral Health (DBH). This will provide critical data, useful to ascertain census and demographic data on hours spent restrained or secluded, admissions, length of stay, discharges, transfers, readmission, and unusual incidents (aggressive behavior, assault, psychiatric emergency, etc.). This metric could be helpful for mental health patients, as well as performance metrics for staff such as reported adverse drug reactions and percentage of missing documentation (Department of Behavioral Health, 2021).

Mandatory Off-site Care. All inmates who enter the facility undergo a mental health evaluation as part of the Department of Corrections intake process. The results of such an evaluation may require referral to a mental health clinician for more rigorous assessment to determine an appropriate treatment plan (Department of Corrections, 2021). Such evaluation eliminates the possibility for inmates to engage in malingering, which is the “falsification or profound exaggeration of illness (physical or mental) to gain external benefits” (Alozai & McPherson, 2021).

External facility use should be extended to include the transport of incarcerated persons experiencing an acute mental health crisis at the D.C. Jail In instances where an individual is a physical threat to themselves, others, or staff, they should be relocated to the primary facility, Saint Elizabeth’s Hospital in Southeast D.C. for treatment. St. Elizabeth’s has been the primary facility for behavioral health services in line with the contract for the Department of Corrections (DOC) Inmate Comprehensive Medical Services being fulfilled by Unity Health Care.

Long-Term Policy Recommendations:

Long-lasting solutions for mental and behavioral needs require new, bold legislation and health care improvements throughout the District of Columbia.

Mandatory Mental Health Training for Correctional Officers. All correctional officers must complete the 40-hour training program from the D.C. Health Matters Collaborative to increase understanding of mental health needs in the community and provide de-escalation techniques.

Mental Health Crisis Response System. A crisis response system should include, “mobile crisis response and stabilization, residential crisis services, . . . hand-offs to home- and community-based services, and ongoing care coordination” (National Association of State Mental Health Program Directors, 2020). The National Alliance on Mental Illness (NAMI) notes an effective crisis response system is available 24 hours a day (NAMI, 2021); these services must be available to anyone, anywhere and anytime, regardless of the payer (DC Health Matters Collaborative, 2021).

A behavioral health crisis system refers to the “organized set of structures, processes and services that are in place to meet all the urgent and emergent behavioral health crisis needs of a defined population in a community, as soon as possible and for as long as necessary” (Group for the Advancement of Psychiatry, 2021). Our recommendation for a D.C. crisis system for behavioral health utilizes existing mental health facilities at D.C. area hospital, along with data-sharing and suggested policy reforms.

Geographic Access. As an urban area, the average commute to a crisis care facility is 30 minutes. The commute to the jail and wait time after medical team arrival is 15 minutes or less (Group for the Advancement of Psychiatry, 2021). Because of the congested streets of D.C., we recommend a drive time of no more than one hour to receive crisis response, as well as one hour travel time to the jail and a wait time of 15 minutes or less upon arrival. This ensures all potential treatment hospital facilities fall within the one-hour time frame recommendation

Network Adequacy. While there is no evaluation standard to determine the need for crisis services in a given area, the National Action Alliance for Suicide Prevention (NAASP) suggests an estimation of 200 persons suffering a behavioral health crisis per 100,000 persons each month. According to census data from 2019, the District of Columbia has a population of about 706,000, which based on the NAASP guideline would necessitate mental health accommodations for just over 1400 persons (United States Census Bureau, 2021). The recommended ratio of population to mental health accommodation is far above what is currently available in D.C. We recommend increased capacity in mental health accommodations at public and private behavioral healthcare

facilities. These facilities should be equipped to care for crisis situations, routine evaluation, and continued treatment. This will require the utilization of St. Elizabeth's and incorporation of the following hospitals to provide inpatient services for individuals suffering from a mental health crisis: MedStar Washington Hospital Center, Howard University Hospital, George Washington Hospital, Psychiatric Institute of Washington, MedStar Georgetown University Hospital, and Sibley Memorial Hospital.

Cost Efficiency. Balancing a budget is a crucial function of an administration, and the D.C. government and the administrators of the DC Jail have an exceptional amount of oversight. Within the contract awarded to Unity Health Care Inc. as the contractor for inmate comprehensive medical services for DOC inmates (Office of Contracting & Procurement, 2019), UHC are required to contact and utilize the services of D.C. Fire & Emergency Medical Service (FEMS) in the event of the necessity of emergency transport services. Basic life support (BLS) level care and ambulance transport provides basic treatment, which would all be sufficient in a situation whereby an individual is suffering an acute mental health crisis and requires medical transport to an area hospital (Fire and EMS Department, 2021). As of October 1, 2021, BLS transport costs patients \$750 plus \$11.25 per loaded mile, measured from pickup location to receiving healthcare facility. From January 1, 2022, this rate increased to \$1,000 plus \$15 per loaded mile. (Fire and EMS Department, 2021). Comparatively, certified providers such as All American Ambulance (\$500+\$6 per mile) and Butler Medical Transport (\$350+\$11.50 per mile) provide cheaper options. D.C. recognizes 13 EMS response service organizations, all of whom have a lower average base cost and cost per mile than FEMS We recommend a modification to the contract that enables the DOC to subcontract emergency medical transport to any of the available certified service providers in the District. In turn, it would lower ambulatory transport costs, which can be reallocated to other budgetary items within the overall contract or utilized to implement other recommendations.

Data Sharing. The District of Columbia should create policy to ensure effective and accurate data collection and dissemination that allows for service evaluation in relation to desired outcomes (i.e., reduced inappropriate arrests, inappropriate ER admission/readmission, adequate access to care). We also recommend implementing a mental health data network between all area hospitals within the D.C. jurisdiction. This will allow for the smooth conveyance of medical history, diagnoses, treatment plans, medications, primary care doctor, psychiatrist/therapist information, and next of kin for each individual who has received services at an area hospital. This ensures individuals receive similar services regardless of treatment location.

Other general recommendations include:

- Two member teams (an employee skilled in counseling and de-escalation techniques and a medically trained employee), who work together to promptly address crises, serve as alternative/auxiliary to police/EMS, and thereby prevent unnecessary incarceration of individuals who pose no threat of violence or whose crimes are a result of mental illness
- Legislation to include aspects of S.1902 Behavioral Health Crisis Services Expansion Act sponsored by Sen. Catherine Cortez Masto (D-NV) for addressing mental health crises and providing crisis service, such as eliminating the requirement for insurance provider authorization or referral and making all individuals eligible for services regardless of ability to pay.
- The District of Columbia's Office of the Deputy Mayor for Planning and Economic Development must develop an amendment to the St. Elizabeth's East Campus Redevelopment plan that requires a fixed amount of commercial property be dedicated to the provision of mental health care services to members of the community and the District at large.

We recognize potential impediments in implementing these recommendations, such as the potential need to revise D.C.'s penal code, or the feasibility of administrative, legislative, and financial change.

Conclusion

Safe cells are intended to safeguard the health and physical wellbeing of an incarcerated individual experiencing a mental health crisis; however, their utilization is demonstrably inhumane and further exacerbates that crisis. Solitary confinement is particularly detrimental for people with mental health needs who frequently face decompensation, due to extreme stress and social isolation (Metzner & Fellner, 2010). The use of safe cells

also leads to adverse physical effects. These negative mental health impacts are long-term, with studies indicating effects may persist for at least one year after solitary confinement (Reiter et al, 2020). The use of safe cells in correctional facilities is contradictory to the D.C. DOC's own policy, which states that people held in solitary confinement are at increased risk of suicide (DOC, 2017). The policy also states that mental health services that are provided must align with the National Commission on Correctional Health Care (NCCHC) Standards (DOC, 2017).

There are alternatives to the use of safe cells, most of which can better support people with mental health needs and at risk of self-harm. Safe cells are an inhumane way to prevent self-harm, especially for those who are experiencing a mental health crisis. Eradicating safe cells is the only option to ensure better mental healthcare for incarcerated individuals. Those who suffer from mental illness are often the most marginalized and mistreated members of society. It is incumbent upon the D.C. DOC to provide incarcerated individuals with humane conditions and adequate mental healthcare.

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Appendix

Appendix 1. Outcomes Matrix

Goals	Criteria	Status Quo	Option 1: Implementation of an Internal PRISM Evaluation	Option 2: Mandatory External Treatment	Option 3: Mandatory Training for Correctional Officers	Option 4: Mental Health Crisis Response System
Effectiveness	Humane conditions (+), improvement in mental outcomes (+), number of incarcerated people who self-harm (-)	LOW Safe cells are inhumane and lead to adverse physical and mental effects	HIGH Evaluation would provide much needed data that would improve mental health outcomes	HIGH Incarcerated individuals would no longer be forced into inhumane safe cells and would receive adequate mental health treatment from healthcare professionals	MED Trained CO staff would result in improved mental health outcomes and reduce inmates who self-harm, although this depends on individual staff	HIGH Crisis response system would vastly improve mental health outcomes and quickly address incidents of self-harm
Cost	Cost to DC government per year (USD)	HIGH Healthcare contract and upkeep of safe cells	LOW Survey costs, staff salaries	HIGH Would be similar to status quo in terms of cost	MED Training facility costs, trainer fees, meals, transportation	MED Well coordinated response system should increase cost efficiency
Equity	Adequate healthcare for people with mental health needs	LOW Safe cells create adverse health effects for people with mental health needs	HIGH Evaluation would provide much needed data that would improve healthcare for people with mental health needs	HIGH Incarcerated individuals would receive adequate healthcare by professional mental health staff	MED Training would increase CO knowledge of the needs of inmates with mental illness, but they may not all comply	HIGH People with mental health needs and people at risk of self-harm would be properly cared for in a timely manner
Administrative Feasibility	Administrative barriers to implementation	N/A	Potential pushback from DOC staff	Complexity around contracting and involuntary commitment at external facilities	Potential pushback from DOC staff	Many services to coordinate and many stakeholders could present administrative issues