

The medical role in solitary confinement

BMA

Guidance for doctors working in the youth justice system

Summary of key points

- The BMA opposes the use of solitary confinement on children and young people and believes that the practice should be abolished. Until this has been achieved, doctors have an important role to play in seeking to minimise the harm to which children or young people are exposed
- Doctors working in the youth justice system are bound by the same principles of medical ethics as they would be in the community
- Doctors should not be involved, either formally or informally, in certifying a child or young person as 'fit' for solitary confinement
- Doctors should raise concerns where they believe solitary confinement will be particularly damaging for a child or young person
- Doctors should visit children and young people in solitary confinement regularly, and raise any concerns they might have about any deterioration in health and wellbeing
- Doctors also have a more general duty to raise concerns about conditions which put patient safety at risk, or about practices which are abusive or negligent
- Children and young people in solitary confinement retain the same rights as other patients to privacy and confidentiality, but these rights are not absolute. They must be balanced against the risk of danger to the doctors involved in their care, and the need to share information in order to safeguard children and young people
- Children and young people at risk of suicide or self-harm should not be accommodated in segregation units, other than in exceptional circumstances where psychiatric or psychological assessment indicates that it will reduce that risk. If it is unavoidable, doctors working in these settings should seek to ensure regular interaction with the patient and raise concerns where they feel health is deteriorating



Background

Isolation, segregation, separation, removal from association, single unlock: these names are used, often interchangeably, across detention settings to describe the practice of solitary confinement, where an individual is physically and socially isolated from others for a prolonged period of time. It can be used for a number of reasons, usually as an administrative measure to manage or simply contain individuals identified as dangerous or disruptive, or as a protective or preventive measure to protect vulnerable detainees from future harm or risk to themselves or others.¹

Its use is widespread in the youth justice system in the United Kingdom, where it is estimated that up to 38 per cent of boys in detention have spent time in solitary confinement,² with stays of over 80 days being reported.³ Compounding this is a growing practice of holding children in conditions of solitary confinement in their own cells or rooms for upwards of 22 hours a day – largely as a result of staff shortages and increased violence in the youth justice system.^{4 5}

There is clear evidence that solitary confinement can have a profound, and lasting, adverse impact on health and wellbeing.^{6 7 8} As a result, we do not believe that its use can ever be sanctioned on children and young people.¹ It is clear, however, that as long as the practice continues, the youth justice system must ensure that the health needs of those in solitary confinement are met.

Doctors working in these settings are a critical part of this, but their role is not without its challenges. The tension inherent in the two competing aims of the secure setting and healthcare – the former seeks to deprive of liberty and punish; the latter to protect and promote health and wellbeing – is at the heart of many of the difficulties doctors face. This tension can be felt most acutely when doctors are placed in proximity to the use of solitary confinement in the youth justice system.

This resource aims to assist doctors working in these settings to maintain the highest ethical and professional standards, while taking into account the reality of working in a secure environment. It is not intended to be an exhaustive guide to the ethical questions that will arise for doctors. Instead, it signposts the type of ethical factors that doctors should take into consideration in making decisions that will best protect and promote the health and wellbeing of the children and young people they care for. When facing specific ethical dilemmas, doctors are strongly recommended to seek advice from the BMA Medical Ethics Department, the General Medical Council, or their personal medico-legal defence body.

What is this guidance about?

This guidance refers to any practice where children and young people are confined to cells or rooms for disciplinary, protective, preventive or administrative reasons, or who by virtue of the physical environment or regime find themselves largely isolated from others. It is intended to capture both formal practices and more informal practices which arise as the result of restricted regimes. For ease of reference, we will use the term 'solitary confinement' throughout this document to refer to any practice where an individual is physically isolated and deprived of meaningful contact with others for a prolonged period of time.

Solitary confinement can be distinguished from other brief interventions. These can include 'time outs' as an immediate response to violent or disruptive behaviour, or situations where a child or young person must be physically isolated to protect themselves or others, including in order to limit the spread of infectious disease.

Where these types of interventions are necessary, we believe they should take place in a non-solitary confinement environment with adequate resources and staff to meet the needs of children and young people. In the case of infection control, the need for transfer to a suitable medical facility should be considered and physical isolation should be carried out only on the advice of public health experts and in conjunction with other recommended infection control measures. Seclusions in psychiatric units that follow established good practice and oversight are not considered solitary confinement.

1 Our position statement and policy recommendations are detailed in a separate document.

This guidance applies across all four nations, and any nation-specific differences will be clearly identified and distinguished. Whilst it expressly addresses the use of solitary confinement on children and young people in the youth justice system, the vast majority of principles will also be applicable to doctors working elsewhere in the youth secure estate, or those working in adult prisons. Much of the information contained in this guidance will also be of interest to those in management roles who work alongside health professionals in these settings.

When and how is solitary confinement used in the youth justice system?

- In England and Wales, children and young people can be isolated for the purposes of ‘good order or discipline’ (GOOD), or where it is in their own interests, for up to three days. It can be authorised by the Secretary of State for up to 14 days, and can be continuously renewed.⁹
- In Scotland, children and young people can be isolated for the purposes of maintaining GOOD, protecting the interests of any prisoner, and ensuring the safety of others, for up to three days. An extension can be authorised by the relevant Scottish Minister.¹⁰
- In Northern Ireland, children and young people can be placed on a regime called ‘single separation’, where it is necessary in their best interests, or as part of an overall strategy to prevent or defuse incidents of violence or aggression. It must be used for the shortest possible time, and in accordance with time limits and arrangements approved by the Secretary of State.¹¹
- There are no central data on the prevalence or duration of solitary confinement. Some estimates suggest that up to a third of children and young people will spend time in solitary confinement,^{12 13} with the duration of confinement ranging anywhere from an average of 8 days,¹⁴ to up to 60 or 80 plus days.^{15 16}
- Various reviews have been critical of the environment, conditions and regime of solitary confinement.^{17 18 19}
- Informal isolation practices, whereby children and young people are held in their own cells on main accommodation wings in conditions akin to solitary confinement, are becoming more widespread as institutions impose more restrictive regimes to manage the detained population.^{20 21 22}

Guiding principles

All doctors practising in the UK, including doctors working in the youth justice system, are bound by obligations set out by the General Medical Council in *Good Medical Practice* and its supporting guidance. Doctors working in secure environments therefore owe the same ethical duties to their patients as all other doctors. In situations where they find their ethical obligations under pressure, it can be helpful to refocus on their primary obligations, as set out in the following core principles:

- A doctor’s primary duty is to their patient
- Doctors must work to protect and promote the health and safety of patients, and take prompt action if they believe that is threatened or compromised
- Medical care should be provided on the basis of clinical need, impartially, and without discrimination.
- Doctors are personally accountable for their professional practice and must always be able to justify their decisions and actions
- Doctors must recognise and work within the limits of their competence, and take steps to keep their professional knowledge and skills up to date

Additionally, doctors working in secure settings should also bear the following core principles in mind:

- Doctors should provide care that is at least of a comparable standard to that provided in the community
- Doctors should respect patients’ human rights and be mindful of the ways in which they may be compromised
- Doctors should maintain robust standards of professional and clinical independence
- Doctors should identify where services or conditions are inadequate and may pose a threat to health, and raise concerns as appropriate

What are dual loyalties?

Dual loyalties, or dual obligations, are the conflicting demands placed on doctors who have direct obligations to their patients, as well as to a third party.²³ Whilst all doctors have various professional loyalties – for example, to colleagues, to employers, or to society at large – these largely remain in the background to their primary obligation to the patient and to the public's health. For doctors who work in secure settings, these dual obligations can become more pronounced.

As noted in the introduction to this document, there is an inherent tension between the two competing aims of the secure setting and healthcare: while the secure setting is a place of punishment, focused on security and deprivation of liberty, healthcare exists to protect and promote the health of those detained. Medical involvement in, or proximity to, disciplinary or administrative issues, such as solitary confinement, is an area where that tension can be seen most clearly. Doctors may find themselves drawn into processes and procedures designed to meet the aims of the secure setting, with the potential for their ordinary duties and obligations to the patient being overridden. It is vital that doctors remain alert to the ways in which such conflicts can impact on their ability to meet their binding ethical obligations.

Should doctors confirm that someone is fit to be placed in solitary confinement?

In the same way as for doctors working in the community, the primary duty of a doctor working in a secure setting is to their patient. Being involved in disciplinary or administrative issues within a secure setting would therefore directly contravene that primary duty – and this extends to certifying someone as fit to withstand solitary confinement. Various international standards clearly state that doctors should not be involved in 'fitting' someone for solitary confinement.^{24 25}

The relevant legislation in the UK does not require doctors to certify individuals as 'fit' for solitary confinement and doctors should avoid being drawn into informal certification processes. Legislation generally requires a healthcare professional to be informed that an individual is being placed in solitary confinement, either before, or immediately after it has happened.

Assessing the patient's health and wellbeing should be distinguished from 'fitting' someone for solitary confinement, as the decision to place someone in solitary confinement has already been made. The role of the healthcare professional in these circumstances is to provide a healthcare assessment as part of standard clinical care in the detention setting. This fine line between certifying someone as fit for solitary confinement and providing care and treatment in line with a doctor's duty to their patient illustrates the tension at the heart of dual loyalties.

Should doctors object to the use of solitary confinement on certain individuals?

Although doctors should not be involved in certifying someone as 'fit' for solitary confinement, they may have a protective role to play in raising concerns about individuals who may be particularly vulnerable to harm. Most of the relevant UK legislation contains provisions to that effect. In England and Wales, doctors must inform the governor of any medical reasons why someone should not be placed in solitary confinement.²⁶ In Scotland, the Prisons and Young Offender Institutions Rules go further and state that institution governors must give effect to a doctor's recommendation that a person should not be in isolation.²⁷

The idea behind this principle is that there are some individuals for whom solitary confinement will be particularly harmful. This level of involvement may still be ethically uncomfortable for doctors, as in excusing some individuals they may be seen to be implicitly sanctioning or acquiescing to its use on others.

The best way to prevent harm to children and young people inflicted by the use of solitary confinement is to cease the use of solitary confinement, and we have been actively calling for such a policy change. We believe, however, that as long as it continues to be used, doctors have an important role to play in protecting the health and wellbeing of children and young people by raising concerns which should, if the doctor's advice is heeded, ensure that harm is kept to a minimum.

Do children and young people in solitary confinement lose their rights to healthcare?

Children and young people in solitary confinement do not lose their rights to healthcare. They should be visited regularly by a healthcare professional for the duration for which they are confined. This is typically done on a daily basis.^{28 29 30} Children and young people in solitary confinement should also be able to request medical attention and to receive clinically appropriate treatment and care.

Providing healthcare to children and young people in solitary confinement brings with it various challenges, particularly in relation to time and resources. Children and young people who are on a restricted regime in their own cells or rooms will require an escort to health services which, due to staff shortages, is not always available. This leads to a greater risk of appointments being cancelled or not attended.

Additionally, doctors working in the youth justice system already have to manage a high workload, exacerbated by the fact that many children and young people will have complex needs or exhibit challenging behaviour. Children and young people who are in solitary confinement may have some of the most complex needs, which may have been manifest in the behaviour that led to their confinement. Children and young people in solitary confinement also retain the same rights to confidential medical examinations and confidentiality of their medical files. Medical examinations of someone who is in isolation should be carried out in a manner which respects the patient's right to privacy and allows for confidentiality to be maintained. This can be particularly challenging to ensure in segregation units because of the security arrangements in place.

Consideration must of course be given to the safety of healthcare staff, and there may be instances where an individual has a history of violence or threats. The aim should be for doctors to see the young person either alone or with another member of healthcare staff. The need to preserve the patient's rights to privacy and dignity must, however, be balanced against the risk of danger to the doctor and other members of the healthcare team. If deemed necessary, a member of prison staff may be within discreet proximity, but out of immediate earshot. Doctors should be mindful of considerations of both safety and confidentiality, and should discuss arrangements with management if they feel that either priority is not being met.

There may be circumstances where doctors may be privy to confidential health information which they may need to share in order to protect detained children and young people. A clear example of this is when a child or young person confides in the doctor that they are feeling suicidal or wish to harm themselves. Doctors need to share this information with the relevant staff members so that appropriate safeguarding arrangements can be made. Doctors should observe the general principles relating to the disclosure of information, by ensuring that only relevant health information is shared, and on a strict 'need to know' basis.

Should doctors raise concerns about the health or welfare of a child or young person in solitary confinement?

As noted above, doctors should regularly visit children and young people for the duration that they are in solitary confinement. This is not done with the purpose of monitoring how long an individual can withstand solitary confinement, but is part of good practice and providing needed clinical attention and care.

If, during the duration of the solitary confinement, doctors become concerned about the health and wellbeing of the child or young person, or identify a deterioration in their health, they should report their concerns to those responsible for reviewing the solitary confinement decision. This should prompt consideration of whether solitary confinement should be maintained, and doctors may again feel a tension between providing care, and being involved in disciplinary processes. At all times, the doctor's role should be focused on protecting and promoting health and wellbeing, and taking prompt action to prevent that from being threatened or compromised.

Respect for confidentiality should never be seen as an insuperable barrier to raising concerns, but wherever possible, the patient's consent should be sought before information is reported to the

relevant person.

Doctors also have a more general duty to raise concerns about conditions which put patient safety at risk, or about practices which are abusive or negligent. All organisations should have clear mechanisms in place for reporting concerns, and in the first instance, doctors should speak to the governor in charge of the establishment. Where this is not practicable, doctors may need to contact the relevant area manager, or a senior colleague within their Trust.

In the event that those concerns are not addressed, doctors may wish to consider going beyond reporting their concerns to a wider disclosure. The key question for doctors is whether their responsibility to protect and promote the health of patients can best be discharged by pursuing their concerns. These decisions can be very difficult for doctors and are often best taken through discussion with colleagues or relevant medical defence bodies.

The BMA has produced detailed guidance on raising concerns, which can be found at bma.org.uk/advice/employment/raising-concerns. BMA employment advisers can also offer more detailed support and advice to members.

What if there is disagreement between doctors and other staff?

As noted above, in Scotland, institutions must act on a recommendation from a doctor that someone should not be held in solitary confinement. Similar provisions do not exist in England, Wales and Northern Ireland. We believe that where a doctor is of the view that a child or young person should not be subject to isolation, and makes a recommendation to governors to that effect, that recommendation must be respected and acted upon.

If, after discussion, agreement still cannot be reached between healthcare staff and other staff as to the appropriateness of solitary confinement, doctors should express their concerns about the health and wellbeing of an individual in the strongest possible terms, and press for alternative arrangements to be made. In the event that their concerns are not adequately addressed, doctors may wish to explore other options for voicing their concerns, as outlined in the section above.

Should solitary confinement be used to treat children and young people at risk of suicide or self-harm?

We are increasingly concerned by reports of solitary confinement being used to manage children and young people at risk of self-harm or suicide, or experiencing other mental health crises. The environment of the segregation unit is a far from therapeutic environment for individuals experiencing a deterioration in their mental health. Lord Carlile, in his inquiry into the use of physical restraint, solitary confinement, and strip-searching, described solitary confinement conditions as 'inducements to suicide'.³¹ The staff working in segregation units are there only to observe and ensure detainees do not attempt suicide or self-harm, but are unable to provide clinical or therapeutic support.

Children and young people at risk of suicide or self-harm should be identified and registered on an appropriate pathway – for example, the Assessment, Care in Custody and Teamwork (ACCT) in England, or the Assessment, Care, Teamwork (ACT 2) in Scotland. This should ensure that they are appropriately monitored and receive the appropriate care and treatment.

They should not be isolated in segregation units other than in exceptional circumstances, for the shortest possible time, where psychiatric or psychological assessment indicates that there is no other way of managing the risk. As noted above, doctors have a crucial role to play in raising concerns with management and pressing for more appropriate arrangements to be made. Where it is simply unavoidable, doctors should ensure they maintain regular contact and interaction with detainees in order to mitigate the harmful effects of segregation as far as possible.

Endnotes

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