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# Reforming Solitary-Confinement Policy — Heeding a Presidential Call to Action

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In January 2016, President Barack Obama addressed the overuse of solitary confinement in U.S. jails and prisons. Calling the practice “an affront to our common humanity,” he described a young man’s suicide, cited medical research on isolation’s “lasting psychological consequences,” and noted that, since more than 95% of prisoners are eventually released from prison, solitary confinement most likely corrodes public safety. He announced a ban on solitary confinement in federal prisons for juveniles and for adults who have committed low-level infractions, as well as an increase in the amount of time prisoners should be allowed to spend outside isolation cells (to exercise, for example).

Solitary confinement generally entails holding a prisoner alone in a cell roughly the size of a parking space for 23 hours per day with up to 1 hour daily for solitary exercise, often in a small cage.<sup>1</sup> Such confinement may last from days to decades and is typically used as punishment for rule violations, though it’s also used for protective custody (e.g., for elderly or lesbian, gay, bisexual, transsexual, or intersex inmates) and for inmates who might pose a threat to others (e.g., because of gang affiliations).<sup>2</sup> According to a recent report by the Bureau of Justice Statistics, over the course of a year, nearly 1 in 5 U.S. prisoners spent time in solitary confinement, which means that we impose this “double punishment” — incarceration plus soli-

tary confinement — on approximately 400,000 people each year.

Obama’s announcement raises important questions that we believe underscore the obligation of leaders from the health professions to work toward reform of solitary-confinement policy. For example, why ban solitary confinement for juveniles but not for other medically vulnerable populations such as older adults? Should persons with a chronic illness such as diabetes, hypertension, or heart failure be held in isolation, given that limited life-space mobility has been linked to increased risks of complications and death? How much time does a prisoner need to spend outside a cell to eliminate health risks related to deconditioning and sensory deprivation?

These questions are critical for prisoners’ health. Yet aside from conducting some important studies that have linked even relatively brief isolation to worsening mental health,<sup>1,3</sup> the medical community has been largely absent from the national debate over solitary confinement.

That absence is conspicuous. Health care professionals have worked diligently to improve patients’ environments by, for example, establishing quality-of-care metrics for hospitals and improving conditions in long-term care facilities. With more than 1.5 million Americans already in prison and nearly 13 million more confined to jails each year, these facilities essentially constitute large health care

settings for historically underserved patient populations. We believe the health professions have a responsibility to work with criminal justice policymakers to assess the risk of health-related harm underlying correctional practices such as solitary confinement.

Fortunately, a compelling model for such a partnership exists. We recently visited a Norwegian maximum-security prison housing 250 men, many of them serving long sentences for violent crimes. We asked the warden how many prisoners were being held in isolation and were surprised to hear his answer: one. That morning, a prisoner had trashed his cell. Guards, using motivational interviewing strategies, tried unsuccessfully to defuse the situation. The man was now cooling off in isolation under the close supervision of a health care team.

“As soon as he calms down,” the warden told us, “he will return to the general population.”

We asked how long that might take.

“Tonight?” the warden guessed. “Tomorrow, certainly.”

In a U.S. prison of the same size, we would expect to find 25 prisoners in solitary, and roughly half of them would be confined for more than a month. But here there was only one, serving less than 1 day, with enhanced attention rather than minimal human contact.

The Norwegian criminal justice leaders we spoke with told

us that 20 years ago their correctional system resembled ours: overcrowded and violent, with frequent use of solitary confinement. Then, motivated by prison riots, Norwegian leaders undertook broad reform. The warden told us that a clarifying moment for him came when he considered a friend's experience as a hospital-based psychiatric nurse. In many ways, the friend's challenges in providing high-quality care to hospitalized patients with complex conditions were similar to those the warden faced with prisoners — both populations could benefit from a compassionate, patient-centered approach with access to resources that could help them learn prosocial behavior.

From high-ranking officials to prisoners, everyone we spoke with in Norway's criminal justice system said their system's primary goal was to make prisoners "better neighbors" when they're released. To accomplish this goal, they believe, people in prisons — like hospitalized patients — require targeted treatment delivered with compassion and humanity. Today, such "treatment" may mean health care, a paying job, education, or short, earned "prison leaves" to visit with family. The result — a system whose policies target social rehabilitation for the sake of community well-being — echoes fundamental principles of medical ethics, particularly those emphasizing "compassion and respect for human dignity and rights" and physicians' "responsibility to participate in activities contributing to the improvement of the community and the betterment of public health."<sup>4</sup>

Many Americans may dismiss

Norway's practice of using solitary confinement as a short-term response to an acute problem, believing that an approach that works in small, homogeneous Norway may be unrealistic in our large, diverse criminal justice system. But Norway's prisons are at capacity — the country exports prisoners to the Netherlands to avoid overcrowding — and their populations are diverse. More than 20 ethnic groups were represented at the prison we visited, including groups from Poland, Latvia, and West Africa. Yet incidents of violence, among pris-

lenges, and solutions based on scientific evidence but lacking a human rights framework will not provide the resources and personal agency that inmates require to get out and stay out of prison.

The Norwegian approach to solitary confinement is not perfect. Norway's use of pretrial isolation has rightly been criticized, and some Norwegian prisons — illegally — use solitary confinement for punishment.<sup>1</sup> But the system marries evidence and compassion without jeopardizing its retributive mission. Prisoners

***With more than 1.5 million Americans already in prison and nearly 13 million more confined to jails each year, these facilities essentially constitute large health care settings for historically underserved patient populations.***

oners or between prisoners and staff, are exceedingly rare. "The respect and humanity are universal," noted the deputy warden. "Those concepts work with foreigners as well as Norwegians. It doesn't matter if you don't like it. Instead, you should ask: 'Does it work?'"

This conjoining of scientific inquiry ("does it work") with human rights ("respect and humanity") is central to both the Norwegian criminal justice system and medicine. We believe it is also essential to advancing reform of the U.S. criminal justice system: a focus on human rights without scientific evidence risks failing to address critical health, economic, and public-safety chal-

lenges in Norway experience serious punishment: their liberty is severely restricted, their regular lives are suspended, and their contact with the outside world is limited.

The medical community can respond to President Obama's recent action on solitary confinement by questioning the health-related consequences of isolating more than 400,000 persons in our jails and prisons each year. Medical leaders, scholars, and practitioners can leverage existing evidence to support arguments for reform and advance those arguments through the academic literature, the lay press, and position papers from medical professional associations.

New research on the health consequences and costs associated with solitary confinement is also needed and would be consistent with the goal of the National Institutes of Health of reducing health disparities that affect underserved populations.<sup>5</sup>

In heeding the president's call, we have the opportunity to fulfill the American Medical Association's third principle of medical ethics: "a physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of

the patient."<sup>4</sup> We can start by speaking up about the medical importance of significantly limiting our country's use of solitary confinement.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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## When New Medicare Payment Systems Collide

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Since 2012, the Centers for Medicare and Medicaid Services (CMS) has introduced more than a dozen new Medicare payment models. Most of them emanate from the Center for Medicare and Medicaid Innovation (CMMI), whose strategy is to launch various initiatives, evaluate them rapidly, and expand those that reduce spending without harming quality of care.<sup>1</sup>

Accountable care organization (ACO), bundled-payment, and patient-centered medical home models currently account for most of the spending in these initiatives, many of which have grown quickly. By 2016, a total of 8.9 million seniors were attributed to Medicare Shared Savings, Pioneer, or Next Generation ACOs, accounting for about \$85 billion in Part A and Part B spending.

In October 2015, CMS announced that 415 acute care hospitals, 305 physician groups, and 723 skilled nursing facilities had entered the Medicare Bundled Payments for Care Improvement (BPCI) initiative, where they could elect to be paid a bundled price for up to 48 defined clinical episodes. Most participants joined Model 2, whose bundles begin with a hospitalization and include all related services for up to 90 days after discharge, or Model 3, whose bundles begin with admission to a post-acute care facility or home health care. Total BPCI spending most likely exceeds \$10 billion annually. Medicare's mandatory bundled-payment program for total joint replacement began in April and will account for \$2.5 billion to \$3 billion in payments annually.

In March, CMS announced

that it had reached its goal of shifting 30% of Medicare payments into alternative payment models (APMs) by 2016. It must expand these initiatives rapidly to reach its 2018 goal of 50% of payments in APMs.

More payment models are coming. The Medicare Access and CHIP [Children's Health Insurance Program] Reauthorization Act (MACRA) of 2015 will change the way Medicare pays physicians beginning in 2019. It creates an APM "track" for physicians who receive a high proportion of their Part B payments through approved APMs — starting at 25% in 2019 and rising to 75% in 2023. Physicians on this track will receive 5% annual bonuses through 2024 — and avoid the administrative requirements and uncertainties of the new Merit-Based Incentive Payment