

The Effects of the Misuse and Overuse of Seclusion, Restraint, and Solitary Confinement
Procedures on Mentally Ill Inmates and Recommendations for Future Use

Approved: Dr. Cheryl Banachowski-Fuller

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Procedures on Mentally Ill Inmates and Recommendations for Future Use

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Jessica Nachtigal

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Abstract

The growing number of mentally ill inmates within our correctional system in the United States provides the correctional system with many unique issues and concerns. Managing mentally ill inmates can be difficult and can pose a threat to the safety and security of the individual inmate and to the institution as a whole. The specific concern that this paper will focus on is the use of seclusion, restraint, and solitary confinement with mentally ill inmates. Currently, there is a concern over the effects of the misuse and overuse of seclusion, restraint, and solitary confinement on mentally ill inmates. The use of these procedures can have detrimental impacts to those with mental illness they are used too often or for an extended period of time. In order to better understand these issues, this paper will discuss what seclusion, restraint, and solitary confinement procedures are, how they are being used, what effects they have on mentally ill inmates, and will provide recommendations for the future use of said procedures.

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I. Introduction

Within the field of criminal justice, there are many new and evolving issues every day. When turning to the correctional system, the changing and evolving issues that continue to face those in the field everyday include how to properly handle, manage, and treat mentally ill inmates. As the number of mentally ill inmates grows within the prisons, jails, and forensic institutions, the procedures used, and the policies adapted and used need to grow and evolve within. Specifically, in this body of research, the policies that dictate how to use the use of seclusion, restraint, and solitary confinement on mentally ill inmates, needs to be better evaluated.

Statement of the Problem

As most of the criminal justice field and criminal justice professionals know, the growth of the mentally ill inmate population continues to grow at an alarming rate within our correctional system (“Position Statement 56”, 2015). The focus of this research will be on a specific issue that the correctional/institutional system faces which is the overuse and/or misuse of seclusion, restraint, and solitary confinement procedures with mentally ill inmates (populations). Specifically, this research will focus on how seclusion, restraint, and solitary confinement procedures are influenced by the policies that dictate their use and if there are any recommendations that can be made to these policies in order to assure that these procedures are used with as little risk as possible. Seclusion, restraint, and solitary confinement procedures are widely debated topics within the criminal justice system and have many issues and effects associated with them, including: re-traumatization, inmate injury, staff injury and more (Smith, Ashbridge, Altendor, Steinmetz, Davis, Mader, & Adair, 2015). Seclusion, restraint, and solitary confinement procedures are used for a number of reasons including physical aggression, self-

harm behaviors, administrative purposes, disciplinary purposes, etc. (Oster, Gerace, Thomson, & Muir-Cochrane, 2016), (Nolan & Amico, 2017). Currently, our country is facing the topic of the misuse and overuse of these procedures which lead to devastating consequences within mentally ill inmate populations.

Seclusion and restraint procedures that are used more often in forensic mental health institutions have been researched in the United States and found to have devastating and long-lasting impacts upon inmates and on the staff, who care for them within mental health inpatient facilities. It was found that the use of seclusion and restraint was not only non-therapeutic but could also re-traumatize the inmate and increases the risks of physical and emotional injury to inmates and the staff performing the procedures. (Ross, Campbell, & Dyer, 2014). It has also been found that the use of seclusion and restraint can lead to psychological harm, physical injuries, and in extreme cases, death, among those subjected to it and the staff that apply these procedures. The injury rates to staff in mental health institutions/facilities that use seclusion and restraint procedures have been found to be higher than injuries among staff in high-risk industries (Alternatives to Seclusion and Restraint, 2015).

Along with seclusion and restraint, we must also look at the use of solitary confinement within mentally ill populations. According to another study, around at least thirty percent of inmates in solitary confinement are mentally ill. This high percentage is a result of the disproportionate number of mentally ill inmates who are isolated from the general prison populations as well as the negative psychological impacts of isolation caused by solitary confinement (Knowles, 2015). Solitary confinement can cause severe psychological pain and suffering for inmates without previous diagnosed mental illnesses. Some believe that it amounts to torture or cruel, inhumane, or degrading treatment or punishment when used as a punishment

and indefinitely or for a prolonged period for individuals with mental illness (Nolan & Amico, 2017). This is because the effects of solitary confinement on individuals with mental illness are aggravated due to the fact that prisoners in solitary confinement do not receive meaningful treatment for their mental illnesses. The quality of mental health treatment in many prisons and jails is inadequate and the problems in supermax prisons and segregation units are even greater because the extreme security measures in these facilities. Due to the extreme security measures, appropriate mental health treatment is hard to provide and in some cases is impossible (ACLU Report, 2014).

In 2000, President Clinton signed into law specific rules regarding the use of seclusion and restraints with residence in mental health care facilities. The law addresses when seclusion and restraints may be used, procedures and holds that are allowed, and the protocols on how to manage a secluded or restraint person. This is one step towards the goal of this study which is to address and recommend appropriate use and management of these procedures with mentally ill inmates (populations). There is also a consensus among many policymakers, officials, and experts within the criminal justice field that reforms need to be made to combat the overuse of solitary confinement, with more than 30 states attempting reforms (Nolan & Amico, 2017). With this knowledge and research being conducted, criminal justice professionals have a responsibility to question when the use of these procedures is appropriate, how they should be monitored to decrease these effects, what can we do to improve them and how should we proceed with ensure safety and security procedures and protocols in the future. The continued overuse, misuse, and improper procedures of seclusion, restraint, and solitary confinement need to be addressed and changed/reformed for the future of our criminal justice system.

Purpose of the Study

The purpose of this research is to give an overview of the seclusion, restraint, and solitary confinement procedures that are used within forensic mental health institutions and prisons and describe the effects of using these procedures with mentally ill inmates (populations). From this overview, the argument will be made that our criminal justice system needs to improve on and properly use seclusion, restraint, and solitary confinement procedures with mentally ill populations. In the second section of this paper, the literature review will look at the definitions of seclusion, restraint, and solitary confinement. The history of the use of these procedures and the current statistics on their usage will also be discussed in order to understand the background and evolution of these procedures. In the third section of the paper, a theoretical framework will focus on how the misuse and overuse of seclusion, restraint, and solitary confinement procedures are related to theories that explain the reasons they are used and the effects.

Not only do using these procedures effect the inmates that they are used on but there are also issues and effects on institutions and prisons as a whole and many ethical concerns that come along with the use of them. After looking at these procedures and data, recommendations will be given on the best use of these procedures based on the effect they have on this vulnerable population within corrections. The goal is to find a way to utilize these procedures with the best outcomes possible. Eliminating the use of seclusion, restraint, and solitary is not the goal of this research, rather finding ways to make sure that the policies that maintain these procedures are used in safe, effective, and efficient ways. Recommendations given from this research will also briefly address the need for proper training and educational resources for staff that use these procedures. The purpose and goal of these recommendations is to make sure there are proper safeguards and policies in place for seclusion, restraint, and solitary confinement procedures. If

performed incorrectly or if monitored incorrectly, seclusion, restraint, and solitary confinement procedures can compromise safety and security. In some cases, seclusion, restraint, and solitary confinement procedures are necessary to maintain safety and security measures and in some cases the well-being of a mentally ill offender (Recupero, Price, Garvey, Daly, & Xavier, 2011). With proper training and educational resources for staff who utilize these procedures, along with well written policies and proper oversight, it may be possible to help lower the risks associated with these procedures and allow safer outcomes.

Significance or Implications of the Study

This study is significant because of the growing mentally ill population that our correctional system is facing. Mentally ill inmates pose many different needs, challenges, and issues within the correctional system and the procedures we use to seclude, restrain, and confine them can pose different risks, issues, and concerns compared to inmates without mental illnesses. By understanding the use of seclusion, restraint, and solitary confinement procedures, it allows for a conversation on the effects that their use can have on the mentally ill inmates/populations that are worked with in corrections and the research will provide the needed recommendations on how to approach these procedures in the safest, most humane way possible while maintaining safety and security within our institutions and prisons. This study will argue that when trained, practiced, and implemented appropriately; seclusion, restraint, and solitary confinement procedures can be used with the mentally ill population within the institutional and correctional setting within reason and with safe and specific parameters. The study will also highlight what the significant effects of overuse, abuse, or improper use of these procedures can have within this population. The overall goal of the research will be to give an overview of this issue, discuss its impact and practice, and make conclusions and recommendations for future use.

II. Literature Review

In the literature review section of this paper, the definitions of seclusion, restraint, and solitary confinement will be discussed in order to fully understand the topic being discussed. This section will also look at the history of the use of solitary confinement procedures, the current statistics of the use of seclusion, restraint, and solitary confinement procedures, and the effects of these procedures when used on mentally ill inmates. Lastly, this section will go over how the overuse and/or misuse of seclusion, restraint, and solitary confinement can affect inmates and staff working with them.

Seclusion, Restraint, and Solitary Confinement: Definition, History, and Current Statistics

The definition of seclusion is known as the involuntary confinement of an individual in a solitary (alone) room or area in which they are physically unable to leave (SAMHSA, 2010). When an individual is secluded, it can create a calming effect for some individual because it reduces the amount of stimuli that the individual is exposed to (Moosa & Jeenah, 2009). Often, seclusion is actually considered to be one form of restraint. There are multiple types of restraints used including environmental, physical, and chemical; all of which are used to immobilize or reduce an individual's ability to move their arms, legs, body, or head freely (SAMHSA, 2010) (Moosa & Jeenah, 2009). Seclusion is known as the environmental form of restraint. By placing someone into seclusion, staff are changing the environment in which they are exposed to. Physical restraints are physical appliances that inhibit an individual's body movement. These types of restraints can range from vinyl restraints (hand, legs, waist, etc.), metal restraints (handcuffs, ankle cuffs, waist chains, etc.), mittens (worn to prevent self-injurious behaviors), and physical body holding techniques (staff physically holding out of control individuals).

Lastly, chemical restraints are any form of pharmaceuticals (medications) used to restrain, sedate, or decrease aggressive and out of control behavior (Moosa & Jeenah, 2009).

While this paper will use the term solitary confinement, solitary confinement is known by multiple different terms including: isolation, administrative segregation, protective segregation, protective placement, disciplinary segregation, permanent lockdown, maximum security, supermax, secure housing, special housing, intensive management, and restrictive housing. Regardless of the terminology, solitary confinement is the confinement or housing of an individual (inmate) with minimal to rare meaningful contact with others. Individuals in solitary confinement are kept in their cells 22 to 24 hours a day. Inmates in solitary confinement experience sensory deprivation and are offered minimal to no educational, vocational, or rehabilitative programming. The difference between seclusion and solitary confinement is the duration/length of time that an individual is kept in this isolative environment. Seclusion procedures are used on a more temporary basis whereas solitary confinement is used for days, weeks, months, and sometimes years on end (NCCHC, 2016).

The history of the use of solitary confinement dates back to the beginning of the penal area in the United States. The first time that solitary confinement was used in the United States was in 1829 at the Eastern State Penitentiary in Philadelphia. The practice of using solitary confinement began based on a Quaker belief that inmates that were isolated with only a Bible would use all their time to repent, pray, and find introspection into their lives and actions. Due to the increase in suicide rates, mental health issues, and other negative effects, the practice was slowly abandoned over time. In 1890, U.S. Supreme Court Justice Samuel Freeman Miller stated against the negative effects of using solitary confinement in support of further discontinuance of its practice. A few decades later, in 1934 the federal government opened Alcatraz Prison which

had a section of the prison that housed inmates in solitary confinement. Most inmates would only spend a few days in this confinement area, one infamous inmate spent six years in solitary confinement at Alcatraz. The use of solitary confinement in Alcatraz and the media coverage on its usage was when the American public was first exposed to the inner details on solitary confinement (Sullivan, 2006).

The current practice of solitary confinement procedures that society knows of today gained momentum after an incident in 1983. In 1983, two correctional officers at an Illinois prison were murdered by inmates on the same day (in two separate incidents). In response to this violent and tragic event, the warden at the time put the prison into lockdown and it became the first prison in the country to start using 23-hour-a-day isolation with no communal yard time. All of the prisons vocational and educational opportunities were suspended and inmates were no longer allowed to eat together. Within a few years, multiple states started to adopt these procedures at other prisons. In 1989, California's Pelican Bay Prison was built to exclusively house inmates in isolation and became the first Supermax facility in the United States. This led to an increase in the building of supermax/control unit prisons including multiple states such as Oregon, Mississippi, Indiana, Virginia, Ohio, and Wisconsin. The United States Bureau of Prisons built the federal government's first and only supermax facility (ADX Florence) in 1994. By 1999, the Department of Justice found that more than 29 states are operating prisons that have 23-hour lockdown or long-term isolation. The growing use of solitary confinement within the U.S. correctional system was highlighted in a 2005 nationwide study conducted by a Florida State University professor, Daniel P. Mears. Mears found that there are 40 states in the U.S. that are operating supermax prisons and that these prisons house more than 25,000 inmates within the U.S. (Sullivan, 2006).

After looking at the history of solitary confinement, it leads into a discussion on more current statistics on seclusion, restraint, and solitary confinement. The goal is now to address the question of how prevalent the use of these procedures is and what the current issues of using them are that have been receiving more attention within the American society. While statistics on seclusion and restraint rates can be difficult to locate, presumably because of health care privacy laws, the following information was available. In one study, it was found that there were approximately 47 seclusion and/or restraint situations each month, per psychiatric treatment facility. This averaged out to approximately 282,000 uses of seclusion and/or restraint in the United States annually (Luna, 2001). Another study, that looked at multiple countries around the world found that in the United States, restraints were used on an average of 7% of patients in rural areas, 6% of patients in suburban areas, 12.3% in urban centers (with populations greater than 1 million) and 9.6% in university-based programs. This data was collected from 51 psychiatric emergency service facilities within the United States. The study also found that the average length/duration of the restraint procedures was 3.3 hours (Sailas & Wahlbeck, 2005).

The use of solitary confinement within the United States has been increasing over the last decades and in recent years its use has received significant attention from national and international human rights organizations (APHA, 2013). It has been estimated that on any given day, there are more than 80,000 inmates housed in restrictive/isolation units across the United States (including prisons and jails) (APHA,2013) (Nolan & Amico, 2017). From this number, approximately 20,000 to 25,000 inmates are being held in the harshest levels of solitary confinement (APHA, 2013). While the focus of this paper's research is on adult male inmates, it is worth noting that while the United States prison population skews male, its solitary confinement population is even more so skewed. A Yale study identified that within 43

jurisdictions there were 59,049 male inmates housed in solitary confinement compared to only 1,458 female inmates (Nolan & Amico, 2017). Other aspects to consider when looking at solitary confinement usage data is the statistics on race and location.

The same Yale study that found differences between solitary confinement usage between male and female inmates also studied the statistics on the race of male inmates comparatively and the states with the most inmates in solitary confinement. The study found that the percent of White inmates in solitary confinement was 31 percent, Black inmates was 45 percent, and Hispanic inmates was 21 percent. When comparing the number of inmates within the prison population compared to inmates housed in solitary confinement, Louisiana and Utah each hold approximately 14-15 percent of their prisoners in solitary confinement. This was the highest of any states included in the study (Nolan & Amico, 2017). The last key information that was discussed in the Yale study that is important to note is the length of time inmates spend in solitary. It found that 18 percent of inmates spend 15 days to 1 month in solitary, 29 percent spend 1-3 months in solitary, 16 percent spend 3-6 months in solitary, 13 percent spend 6 months to 1 year in solitary, 13 percent spend 1-3 years in solitary, 5 percent spend 3-6 years in solitary, and 5 percent of inmates spend 6 or more years in solitary confinement. From this data, it was found that almost half of the inmates in Texas held in solitary confinement had been there for more than three years making it the highest in the nation in this category (Nolan & Amico, 2017).

Effects of Restraint/Confinement Procedures

While the research showing the numbers and statistics involved shows how often and how long seclusion, restraint, and solitary confinement procedures are being used, it is important to understand why these numbers are alarming or of concern. First, in order to understand why

they are concerning, the effects of seclusion and restraint will be discussed. One of the strongest justifications for using seclusion and restraints with individuals in forensic psychiatric settings is for the protection of the individual, others around them, or both. At times psychotropic medications and verbal therapies are not enough to control overly aggressive and dangerous individuals. By using seclusion and restraint, staff working with these individuals are able to control the environment in which they are in to better prevent and avoid future violence/aggression (Moosa & Jeenah, 2009). While in some cases seclusion and restraint procedures are used as a last resort in preventing injuries and maintaining safety and security, it also has many negative effects associated with these procedures (Fereidooni Moghadam, Fallahi Khoshknab, & Pazargadi, 2014). Some of the negative effects of using seclusion and restraint include: physical injury (to the individual or staff involved), negative emotional impacts, psychological distress, further simulation of aggression, damage to therapeutic rapport between the individual and staff, re-traumatization (for those who've experienced past trauma), an increase in future aggressions/violence, and in extreme cases, death (Fereidooni Moghadam, et. al., 2014), (Moosa & Jeenah, 2009), (SAMSHA, 2010).

The use of solitary confinement procedures with inmates that have a pre-existing mental illness/diagnosis can be especially problematic due to their level of vulnerability to the harms and effects of solitary confinement and isolation. In many, if not most circumstances, the use of solitary confinement procedures with mentally ill inmates exacerbated their symptoms and can even make these symptoms worse. It has been found that solitary confinement can have an impact on many health issues including: gastrointestinal and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, profound fatigue, heart palpitations, migraines, back and joint pains, weight loss, diarrhea, and the aggravation of preexisting medical

conditions. These issues also extend to mental health issues (even in those inmates that have not had previous mental health issues) with the effects including: increased anxiety, depression, and anger, lowered impulse control, increased paranoia, the presence of visual and auditory hallucinations, and hypersensitivity to stimuli. Solitary confinement can also give inmates post-traumatic stress disorder (PTSD) and can increase the likelihood of self-injurious behaviors and suicide (NCCHC, 2016), (APHA, 2013). It was found that in New York, the suicide rate among inmates was five times higher among inmates housed in solitary confinement compared to inmates in the general prison population (Cloud, Drucker, Browne, & Parsons, 2015). The effects of solitary confinement can last while the individual is held in isolation but can also extend after their release from solitary confinement and last for years to come. Another issue with using solitary confinement for extended periods of time is that it can limit an inmate's access to necessary and effective medical and mental health care. In most cases, an inmate in solitary confinement receives medical and mental health care from behind cell doors, bars, and in some cases, they are still shackled/restrained. This can be counterintuitive and countertherapeutic to the inmate and health care provider (NCCHC, 2016).

Overuse and/or Misuse of Restraint/Confinement Procedures

While seclusion, restraint, and solitary confinement procedures are currently used for many different reasons, including the safety and security of the institutions they are used in, the problem being address in this paper is about how the misuse and overuse of these procedures increases the likelihood of associated negative effects. Since there are such large and devastating effects that can come from using these procedures, the safe execution, monitoring, and policy regulation of these procedures is necessary. While the goal of seclusion and restraint (when used properly and when necessary) is to maintain safety and security, seclusion and restraint are often

misused to address loud, disruptive and noncompliant behaviors that are the result of power struggles between inmates and staff. This misuse of these procedures is arbitrary, idiosyncratic, and in many cases avoidable (SAMHSA, 2010). The misuse and overuse of solitary confinement is starting to be called cruel and unusual punishment and a form of torture by some organizations and advocacy groups. In 2011, the United Nations special rapporteur on torture, Juan E. Mendez, discussed the need for a ban on solitary confinement that lasts more than 15 days. According to Mendez, due to the severe mental pain and/or suffering that is caused by solitary confinement, it should be considered torture or cruel, inhuman or degrading treatment when it is used as a punishment, indefinitely or for prolonged periods of time for persons with mental illness (Nolan & Amico, 2017).

The use of seclusion, restraint, and solitary confinement not only effects the inmates that is used on, but also the staff members involved in these procedures. Seclusion and restraint procedures can also lead to psychological harm and physical injuries to the staff performing these procedures. One study found that staff injury rates for those working in mental health settings where seclusion and restraint is used are higher than the injury rates for workers in high-risk industries like lumber, construction, and mining (SAMHSA, 2010). The use of seclusion and restraint, as discussed before negatively affects the therapeutic relationship/rapport between an individual and the staff involved. This is problematic not only for the individual but for the staff who spend the time to build these relationships and then have to work to re-establish trust and rapport after a crisis situation occurs (Fereidooni Moghadam, et. al., 2014). Correctional health care providers also face challenges when working with inmates that are in solitary confinement. The obstacles that need to be overcome in order to perform effective medical and mental health

care needs can be difficult to work around. This can lead to health care providers facing ethical dilemmas, privacy and confidentiality issues, etc. (NCCHC, 2016).

Therefore, it is important to have an understanding into the effects of seclusion, restraint, and solitary confinement procedures so that they can be trained, monitored, and practiced in the safest and most humane way possible to avoid the effects or decrease the severity of the effects that are associated with these procedures. This research aims to recommend way(s) to best use these techniques with the least harm possible, in order to maintain safety and security of inmates, staff, and institutions/prisons.

III: Theoretical Framework

In this section of the paper, the concepts of retribution versus rehabilitation will be examined and will be used to explain the reasoning of why seclusion, restraint, and solitary confinement procedures are used. Then, the social isolation theory will be discussed as means of supporting and explaining the negative impacts and effect of these techniques that have been examined in this paper thus far.

Retribution versus Rehabilitation

To begin, the definitions of retribution, rehabilitation, and punishment will be given in order to understand what is meant when these terms are used throughout this section. Retribution is a philosophy within the criminal justice system that holds that individuals who commit criminal acts should be punished based on the severity of their crime they've committed without consideration of any other mitigating factors (Gaines & Miller, 2015) Rehabilitation, in the criminal justice system, is a philosophy that believes that society is best served and protected when individuals who have committed crimes are provided resources that will eliminate

criminality from their behavioral patterns (Gaines & Miller, 2015). Punishment can be defined as any type of pain, suffering, or consequence inflicted on an individual by the authority of the law for a crime or offense committed by that individual (Black's Law Dictionary, 2017). These definitions give a baseline to refer to when discussing the reasons or theory behind the use of seclusion, restraint, and solitary confinement.

Seclusion and restraint are viewed as tools that are used within forensic psychiatry to protect individuals from harming themselves and others. Seclusion and restraint of a violent individual allows for the staff working with them to feel safe enough to perform other therapeutic tasks that can serve and treat them (Moosa & Jeenah, 2009). Seclusion and restraint procedures have become a part of the therapeutic and rehabilitative process used with mentally ill individuals in forensic psychiatry, however, their effects have been questioned. The therapeutic effects and benefits of these procedures are questioned due to the unexpected changes they can cause as a result of sensory deprivation, decreased social interactions, abrupt changes in daily routines, resentments toward staff, and the restriction of individual freedoms (Keski-Valkama, 2010). Due to these effects and the attitudes toward seclusion and restraints, from both those restrained and the staff carrying out these procedures, seclusion and restraint procedures can be seen as more retributive or a form of punishment. While many individuals who have been secluded reported feeling a calming effect and protective environment while secluded, they also said that they felt emotions of anger, disgust, helplessness, and depression. They also reported that they felt as though they were being punished when they were secluded and/or restrained (Keski-Valkama, 2010). It has also been found the staff involved in seclusion and restraint procedures sometimes feel negatively about their use, noting feelings of shame,

fear, distress, and concern over abusing individuals (Keski-Valkama, 2010) (Moosa & Jeenah, 2009).

The use of solitary confinement in the United States started around the 1800's and it was an attempt at a form of rehabilitation rather than the brutal use of corporal punishment. Activists and reformers believed that inmates placed in solitary confinement would be given the silence and solitude that they needed to reflect, repent, and motivate them towards a crime-free lifestyle. These ideas began the use of silent prisons which placed all prisoners in solitary confinement (Cloud, Drucker, Browne, & Parsons, 2015) (Schmallegger, 2017). However, the silent prison system did not last long due to the negative effects and attention that it drew to these institutions. Physicians began to report the patterns of symptoms they saw among the inmates that were placed in solitary confinement. They attributed these symptoms to lack of natural light, poor ventilation, and the lack of human contact that the inmates received. In 1848, Francis Gray, who observed over 4,000 inmates in these silent prisons concluded that, "The system of constant separation...even when administered with the utmost humanity produces so many cases of insanity and of death as to indicate most clearly, that its general tendency is to enfeeble the body and mind" (Cloud, et. al., 2015). While the goal of this early movement in the United States penal system had been rehabilitation, it was abandoned and modified in the following years due the effects it had on inmates.

Up until the mid-1970s, rehabilitation had a large role in prison policy around the United States. Rehabilitation was used to help inmates develop educational and occupational skills and to resolve psychological problems (substance abuse, aggression, mental health issues, etc.) in order to reintegrate into society more effectively. Since then, the United States has developed a "tough on crime" approach and uses punishment as the main purpose of incarceration (Benson,

2003). From around 1972 to 2012, the United States prison population grew at an overwhelming rate (706% growth) and during this time, solitary confinement also rapidly expanded. The use of solitary confinement at this time was used as a punitive method to control the overcrowded jail and prison populations (Cloud et. al., 2015). Most recently, solitary confinement is generally used for one of the following reasons: (1) punishment for an inmate who doesn't follow rules and policies, (2) any safety concerns: which would include inmates who are a danger to staff, other inmates, or are suspected gang members, (3) an inmates own protection: this may include sex offenders, transgendered inmates, and any inmates seen as sexually vulnerable around other inmates, and (4) clinical/therapeutic reasons: which mainly consists of mentally ill inmates who are disruptive to the prison environment (Cloud et. al., 2015) (NCCHC, 2016). With the use of seclusion, restraint, and solitary confinement procedures being used as retribution or punishment, the negative effects of procedures can be seen within the social isolation theory.

Social Isolation Theory

The concept of the social isolation theory can be defined as the number, frequency, and quality of an individual's social contacts; the longevity of these contacts; and the negative emotions or feelings attributed to the isolation that an individual is involved (Luskin Biordi & Nicholson, 2013). As social creatures, humans when left alone for an extend period of time, do not thrive as well as when they have appropriate social interactions. A lack of human connection can increase an individual's anxiety, increase stress hormones, compromise our immune system, and can decrease healthy coping mechanisms. When humans are exposed to sensory deprivation and/or an unchanging environment, the ways in which we process information can change in unpredictable ways (McAndrew, 2016). When inmates are placed into seclusion for extended periods of time or placed into solitary confinement, they are being placed into a state or period of

social isolation. Social isolation is also especially concerning with mentally ill inmates because they are more likely to experience greater social isolation and loneliness. When individuals with severe mental illness are exposed or subjected to social isolation, they experience higher levels of delusions, lack of insight, and a higher need for hospitalization (Wang, Lloyd-Evans, Giacco, Forsyth, Nebo, Mann, & Johnson, 2017). This becomes a concerning issue that can be seen in the long-term effects of the extended use or overuse of these procedures.

Longer stays within seclusion and solitary confinement can have serious emotional and behavioral consequences, especially for those with mental illness or mental health symptoms. While these effects can range from acute to chronic, depending on the length of an individual's isolation, inmates report feelings: irritability, hostility, poor impulse control, stress, panic attacks, hopelessness, mood swings, and thoughts of self-harm and/or suicide (Murphy-Corcoran, 2015). Another major issue that occurs is many of the issues that confined inmates have during their solitary confinement are also prevalent post-isolation. Inmates who are isolated exhibit maladjustment disorders, problems with aggression, and have difficulty adjusting to social contact afterwards. Inmates who experience social isolation have also been found to engage in increased prison misconduct and they express higher hostility towards correctional staff. Positive cases of inmate behaviors after social isolation have been very rare and hard to locate (Murphy-Corcoran, 2015). It is important to note that while isolation can be psychologically harmful to any inmate, regardless of their mental health history and diagnosis, the nature and severity of the effects depend on the individual, the duration of the isolation, and specific conditions of the isolation. Specific conditions would include things like access to natural light, books, radio, family, etc. (Metzner & Fellner, 2010). Therefore, not only does the social isolation of solitary

confinement cause concern, but also the access an inmate has to certain outside connections, also plays a role into these effects as well.

IV. Data/Secondary Research Analysis

This section of the paper will be comparing and contrasting the policies behind the seclusion, restraint, and solitary confinement procedures at different institutions/prisons. This section will examine the seclusion and restraint policies at Mendota Mental Health Institute in Madison, Wisconsin and Montana State Hospital Forensic Mental Health Facility in Warm Springs, Montana. The solitary confinement policies of the Wisconsin Department of Corrections, Louisiana Department of Corrections, and the Federal Bureau of Prisons will also be examined. The goal behind this section is to understand how current policies are shaping the use of seclusion, restraint, and solitary confinement procedures in order to make recommendations for future use.

Compare and Contrast

Mendota Mental Health Institute versus Montana State Hospital Forensic Mental Health Facility-Seclusion and Restraint

Mendota Mental Health Institute (MMHI) is forensic treatment facility located in Madison, Wisconsin. MMHI provides forensic treatment services to male patients which includes: court-ordered competency evaluations, treatment to competency services, and treatment for patients who are found not guilty of criminal activity by reason of mental disease or defect. There are fourteen inpatient units that make up MMHI, one of which is a civil geriatric co-ed unit. MMHI also has an additional unit that houses juvenile males that are referred from the Department of Corrections (MMHI, 2018). Montana State Hospital Forensic Mental Health

Facility (MSHFMH) provides services for patients who are admitted to the Montana State Hospital that are in different stages of adjudication for misdemeanor and/or felony charges. The three main focuses of this forensic program are competency evaluations, treatment to restore competency and fitness to stand trial, and treatment for individuals who are found not guilty by reason of mental illness. This facility also provides evaluations and treatment for individuals who are transferred from the Montana Department of Corrections (MSH, n.d.).

Upon first glance, both the MMHI and MSHFMH policies on seclusion and restraint are thirteen pages long. MMHI labels their policy as Emergency Interventions: Seclusion and Restraint and MSHFMH labels their policy as Use of Seclusion and Restraint at the Forensic Mental Health Facility. Both facilities start their policies with the definitions of seclusion and restraint along with the institution's philosophy on the use of seclusion and restraint. Both institutions agree that seclusion and restraint should be used in the most limited capacity, for the shortest time possible, and with the most respect and dignity for the individual as possible. Both policies agree that seclusion and restraint should never be used as: a sanction, at the convenience of staff, as a reaction to rude, unpleasant, or disruptive behavior, circumstances that are under the facility's control, as a behavioral consequence for previously occurring behaviors, or as a means of coercion, discipline, or retaliation (MMHI Policy and Procedure, 2015) (MSHFMHF Policy and Procedure, 2016).

There are some differences between the two policies on the monitoring of seclusion and restraint and the way that seclusion and restraint physician's or doctor's orders are written. At MMHI, an initial order for seclusion and restraint is written and lasts for one hour. Once the first hour of a seclusion has lapsed, a registered nurse (RN) must initiate a face to face assessment with the individual and if the seclusion or restraint needs to continue, another doctor's order must

be written. This doctor's order can last for up to four hours. If the seclusion lasts longer than this time frame, an additional order is written at each four-hour mark (MMHI Policy and Procedure, 2015). At MSHFMH, the facility follows similar procedures as MMHI, however, the doctor's orders written for seclusion and restraint may last for up to eight hours. This includes the initial orders written. This is twice as long as the standing orders for seclusion and restraint at MMHI (MSHFMHF Policy and Procedure, 2016). Next differences between these two policies is in how seclusion and restraint is monitored. At MMHI, as soon as an individual is placed into seclusion or restraint, a staff member is designated to them for uninterrupted continuous monitoring at the door for the first hour. After the first hour of a seclusion, the staff may continue the uninterrupted monitoring through the use of audio and visual equipment. MSHFMH has similar monitoring guidelines within their policy, however it differs from MMHI policy because at MSHFMH, a licensed independent practitioner or trained RN may modify the first hour of uninterrupted observation and switch it to audio and video monitoring based on their own discretion of the situation. At both institutions, if the individual is in restraints, the uninterrupted continuous monitoring continues at the entrance of the room where the individual is located. Video monitoring is not allowed for individuals who are in restraints. A registered nurse (RN) must also conduct a face-to-face assessment of the individual every hour at both facilities (MMHI Policy and Procedure, 2015) (MSHFMHF Policy and Procedure, 2016).

Other similarities between these policies are in the monitoring timelines of individuals in seclusion and restraints. Both institutions monitor these individuals at 15-minute intervals and try to verbally engage the individual who is secluded or restrained. They also both perform range of motion exercises every two hours for individuals who are in restraints. Individuals are offered meals, snacks, and hygiene (brushing teeth, washing up, etc.) at regularly scheduled times. Staff

also offer fluids and the bathroom to secluded or restrained individuals, at MMHI every 30 minutes or when requested, and at MSHFMH every hour or when requested (MMHI Policy and Procedure, 2015) (MSHFMHF Policy and Procedure, 2016). Another difference between these policies is that in MMHI's seclusion and restraint policy, they note that if an individual who is secluded or restrained falls asleep during the episode, the seclusion or restraint must be terminated immediately. According to the policy, an individual who falls asleep is no longer an imminent threat to themselves or others and therefore, there is no longer justification to keep them secluded or restrained. (MMHI Policy and Procedure, 2015). The MSHFMH policy does not address this issue at all so it is unclear how they handle the same situation. There is also a difference in the time frame in which the institutions require a face-to-face physician's assessment to be completed. At MMHI, it is required every 8 hours whereas at MSHFMH it is required every 24 hours. This is a significant time difference for the face-to-face physician's assessment. MMHI's policy also states that if an individual has a seclusion or restraint episode that extends for more than 12 hours or if there are two or more episodes of seclusion or restraint within 24 hours, it must be reviewed by the unit manager and nursing supervisor. The unit manager or nursing supervisor also will contact upper management to consult them about the situation (MMHI Policy and Procedure, 2015). Overall, there were more similarities between the two policies than differences. Both policies include detail into making sure staff are properly trained before conducting, monitoring, and assisting in seclusion and restraint procedures. Both policies also discuss using seclusion and restraint as a last resort and for as short of a timeframe possible in order to maintain individual's dignity, rights, and prevent traumatizing (or re-traumatizing) them.

Wisconsin Department of Corrections vs. Louisiana Department of Corrections vs. Federal Bureau of Prisons-Solitary Confinement

Due to the structure of how these policies are written, Wisconsin's policy and Louisiana's policies will be looked at first and then compared and contrasted to the Federal Bureau of Prisons. In each respective policy, Wisconsin refers to solitary confinement as administrative confinement and Louisiana refers to it as administrative segregation. Both states have similar definitions for solitary confinement. They list the definition of this form of confinement as the involuntary, segregated confinement of an inmate who poses a risk or threat to life, property, self, staff, other inmates, or to the security and/or orderly running of the overall institution. Louisiana also uses administrative segregation for inmates who are pending transfer to another institution or who are pending assignment or re-assignment within an institution (Louisiana Department of Public Safety and Corrections, 2008). The terminology of Wisconsin's policy says that administrative confinement is nonpunitive, however, Louisiana's policy does not include this. The monitoring and/or review of an inmate in solitary confinement is different between the two states. In Wisconsin, the policy states that an inmate's progress in administrative confinement will be viewed by the administrative confinement review committee (ACRC) at least every six months. If an inmate has been in administrative confinement for a year or longer, the warden and administrator are to review the decision made by the ACRC and decide whether the confinement continues to be necessary (Wisconsin Department of Corrections, 2011).

Louisiana's review of their administrative segregation differs in that their review board is required to review the status of an inmate in administrative segregation at least every seven days for the first two months and then every 30 days after. Louisiana's policy also differs from

Wisconsin's in that it includes a specific rule on the monitoring of mentally ill inmates who are in confinement. If a mentally ill inmate is placed into administrative segregation, a mental health professional is required to document a personal interview with the inmate if they remain in administrative segregation for more than 30 days. A mental health assessment must also be done at least every three months thereafter if the confinement continues (Louisiana Department of Public Safety and Corrections, 2008). Wisconsin's policy does not include this detail into its monitoring.

The Federal Bureau of Prisons (BOP) differs from these two states to begin with in many ways, starting with the different terminology they use to define solitary confinement. The BOP has different types of solitary confinement and they are listed under special housing units (SHU), special management units (SMU), and administrative-maximum (ADX or ADMX). These three types of confinement/units all hold inmates under what is considered as solitary confinement. For the purpose of comparing and contrasting with the other two departmental policies, this paper will focus on the BOP's policy on special housing units, which is most comparative to the other two discussed. When inmates are placed into special housing units, they fall under one of two statuses. The first, administrative detention status, removes inmates from the general prison population in order to ensure safety, security, and orderly operation of a facility (Federal Bureau of Prisons, 2016). This status is considered nonpunitive. This is status's definition is most comparative to the Wisconsin and Louisiana confinement procedures. The second status, disciplinary segregation status is a punitive status that is used as a sanction for committing a prohibited act. When an inmate is placed into SHU, their placement is reviewed by a segregation review official (SRO). If under administrative detention status, this review happens within three days however, if in disciplinary segregation status, this review does not occur. After seven days,

both statuses will have review with the SRO with a hearing the inmate may attend. This switches over to 30-day reviews if the inmate is in continuous placement. If an inmate with a mental illness is placed into SHU, psychology services is to be notified and will conduct a mental health evaluation within 24 hours of the placement. Similar to Louisiana's policy, if an inmate has a mental illness and is placed in SHU, a mental health assessment is done every 30 days for the entire length of the confinement (Federal Bureau of Prisons, 2016). Overall, when comparing the three organizations, it appears as though the policy that goes the most in-depth and into the most detail on its function, is the policy that has been created by the Federal Bureau of Prisons.

V. Recommendations

While many reform groups and activists would like to stop the use of seclusion, restraint, and solitary confinement all together, the use of these procedures is in some cases necessary to ensure the safety and security of these inmates and the institutions they are confined in. In this section, there will be recommendations made for the future use of seclusion, restraint, and solitary confinement procedures with the mentally ill. These recommendations will be made with the goal or hope that they will prevent the negative consequences of their use when at all possible. While these recommendations could be used for the entire inmate population, specific emphasis will be placed on inmates with mental illnesses.

Recommendations for continuing use of seclusion, restraint, and solitary confinement procedures

The first recommendation that will be made is that seclusion, restraint, and solitary confinement should be used as infrequently as possible. With the negative consequences that are caused by the use of seclusion, restraint, and solitary confinement, these procedures should be

used only as a last resort, rather than as common practice. As previously discussed, some of the negative effects of using seclusion and restraint include: physical injury, negative emotional impacts, psychological distress, further simulation of aggression, damage to therapeutic rapport between inmates and staff, re-traumatization, increases in future aggressions/violence, and in extreme cases, death (Fereidooni Moghadam, et. al., 2014) (Moosa & Jeenah, 2009), (SAMSHA, 2010). The use of prolonged solitary confinement also results in serious negative consequences including mental and physical health issues. The mental health issues that can result from the lengthy use of solitary confinement procedures include increased anxiety, depression, anger, lowered impulse control, increased paranoia, visual and auditory hallucinations, and hypersensitivity to stimuli. The physical health issues that result from this practice also include: gastrointestinal and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, fatigue, health palpitation, migraines, back and joint pains, weight loss, diarrhea, and aggravation of preexisting medical conditions (NCCHC, 2016), (APHA, 2013). Instead of institutions relying on these procedures, other alternatives to these procedures should be sought out and put into practice. An approach to an alternative to these procedures can be found within Mendota Mental Health's seclusion and restraint policy. The policy requires a stress reduction inventory to be completed for all individuals within a specified time frame from their admission to the institution. The stress reduction inventory is a tool that is used to identify options that staff can try to use with the particular individual when they become upset, agitated, stressed, etc. By offering these options first, staff are giving less restrictive options for an individual to handle themselves and their behavior in order to avoid a seclusion or restraint episode (MMHI Policy and Procedure, 2015). This type of tool could be used to prevent the need for the use of

seclusion, restraint, and solitary confinement if used appropriately and is one example of an alternative approach to these procedures.

That being said, it is understood that there will be circumstances in which seclusion, restraint, or solitary confinement is needed as a last resort to protect the individual or to maintain safety and security of the institution. In the event that seclusion, restraint, or solitary confinement is necessary, it is recommended that it should be used for the shortest length of time possible. Due to the negative consequences of these procedures that has been discussed earlier in this paper, it is in the best interest of the inmate's mental health to reduce the length of time that they are confined within these restrictive measures. This should especially be taken into consideration since it has been found that inmates in solitary confinement for extended periods of time do not receive necessary and effective medical and mental health care (NCCHC, 2016). By reducing the frequency and length of time that mentally ill inmates are placed under these restrictive measures, it can reduce the chances of deterioration of mental health symptoms, re-traumatization of the inmate, and it supports concepts of trauma-informed care. Using seclusion, restraint, and solitary confinement for the shortest time possible can not only reduce the impact these procedures have while the inmate is within these restricted settings but can also limit the effect that these procedures can have on an individual afterwards as well. As previously discussed, inmates can experience effects post-isolation that can also be detrimental. Inmates have exhibited maladjustment disorders, problems with aggression, difficulty adjusting to social contact, increased prison misconduct, and high levels of hostility towards correctional staff post-isolation (Murphy-Corcoran, 2015). These post-isolation effects can in turn result in the inmate being sent back into a more restrictive or isolative environment due to the behavior or aggression

they may display resulting from these effects. In order to reduce these effects post-isolation, it is necessary to make sure these procedures are used for the shortest length of time possible.

The next recommendation would ask for consistent and adequate monitoring of seclusion, restraint, and solitary confinement procedures. If an inmate is placed into seclusion or restraints, there needs to be specific guidelines in place for the monitoring of the individual to maintain the safety of the individual and control of the situation. These guidelines should be followed during every incident or situation that involves seclusion and restraint and should be performed by well-informed and trained staff members. Any staff member monitoring individuals in seclusion and restraint should be qualified to do so based on training provided to them by the institution they work for. During the monitoring of a seclusion or restraint procedure, trained staff should assess the situation in order to terminate the seclusion or restraint as soon as possible once the individual is calm, safe, and no longer a danger to themselves or others. Documentation that is done while an individual is secluded or restrained should be completed by more than one trained staff member in order to provide multiple witness accounts of the restrictive procedure used. When monitoring someone in solitary confinement, having an in-depth medical and mental-health rounds by professional staff could provide inmates with access to staff in order to report any concerns they are having or feeling. One correctional investigator, Howard Sapers, came up with a list of 104 recommendations for the appropriate use and monitoring of solitary confinement after the death of an inmate with serious mental health issues who was in solitary confinement. One of his recommendation's states "decision-making with respect to the clinical management and interventions of inmates with mental health issues [be] made by clinicians in consultation with the inmate, rather than by security management and staff" (Webster, 2015). This paper would also stand by this recommendation. Decisions that are made for an inmate's

physical and mental health care should only be made by clinicians. If a clinician recommends that the restrictive measures of seclusion, restraint, or solitary confinement need to be terminated due to an inmate's physical or mental health concerns, security staff should follow these recommendations when possible and as soon as possible.

In regard to solitary confinement, it is recommended that inmates with mental illness, especially those with more serious mental illness or those who are currently exhibiting symptoms of their illness, not be placed into solitary confinement unless it is an emergency situation or for a very brief period of time. Inmates with serious mental illness are at high risk when placed into solitary confinement and it can be detrimental to their mental and physical health to place them in this type of environment. These inmates are more likely to engage in self-injurious behavior and attempt suicide in this type of setting. A study in New York found that the suicide rate among inmates was five times higher among inmates in solitary confinement (Cloud et. al., 2015). Many federal courts have ruled that placing inmates with serious mental illnesses in solitary confinement violates the Eighth Amendment prohibition of cruel and unusual punishment (Schlanger & Fetting, 2015). It is safer and more effective to house these types of inmates on units that are designed to specialize with this type of population in order to manage them.

It should also be recommended that when an inmate is placed into seclusion, restraints, or solitary confinement, they should not be placed in an environment of total social isolation or sensory deprivation. Inmates with severe mental illness are more greatly impacted by the effects of social isolation due to their illnesses. Inmates with severe mental illness, who are exposed to social isolation and/or sensory deprivation, experience higher levels of delusions and hallucinations, lack insight, and require a higher need for hospitalization (Wang et. al., 2017).

Those seclusion or restraint should have trained staff engaging with them in a constructive and therapeutic manner in order to bring them to a safe baseline that would allow them to be released from seclusion or restraint. When an inmate is placed in solitary confinement, they should still be allowed access to phone calls, visits, mail, books, etc. in order to keep their time occupied. Due to the effects that the lack of human connection can have on an individual, such as increased anxiety, increased stress hormones, compromised immune systems, and decreased coping mechanisms, any outside resources that an inmate is provided could help the conditions of their isolation (McAndrew, 2016). Having contact with their support systems, staff, and the outside world, can have a positive impact on these inmates, especially if they are in a more restrictive setting. This may help reduce the negative impacts that total social isolation can have on mentally ill inmates.

Lastly, it is recommended that long-term solitary confinement should always be used for safety and security with mentally ill inmates rather than as a form of punishment. In many cases, solitary confinement is used to punish minor disruptive behaviors which could be managed in a more appropriate way rather than by the use of solitary confinement. In a recent report from Illinois, it was found that more than 85 percent of the inmates released from solitary confinement during a one-year period had been placed in confinement for minor infractions such as not standing for count or using abusive language. It was also found that in Pennsylvania that around 85 percent of inmates that failed to obey an order were placed in solitary confinement (Schlanger & Fetting, 2015). With the knowledge of the impact that solitary confinement has on mentally ill inmates it should be imperative to all prison officials to make sure that solitary confinement is not used at punishment or as retribution. With these recommendations in mind and when put into

practice, the goal of reducing the severity of the impacts that seclusion, restraint, and solitary confinement has on mentally ill inmates can be managed.

VI. Conclusions

Overview of Research Found

This paper has identified the definitions of seclusion, restraint, and solitary confinement and discussed how the current procedures and policies behind them are affecting mentally ill inmates. Seclusion, restraint, and solitary confinement procedures are currently a major concern within the United States correctional system due to the social isolation and sensory deprivation they can cause when they are used often or for extended lengths of time. While seclusion, restraint, and solitary confinement procedures are sometimes necessary in order to assure the safety and security of an inmate or the institution itself, it is important for correctional administrators and personnel to know the negative and detrimental effects that these procedures can have on mentally ill populations in order to best manage them.

The discussion on the use of seclusion, restraint, and solitary confinement falling under the retribution versus rehabilitation theory found that these procedures are used more as retribution rather than as a rehabilitative tactic which they were once thought to be. While in the past it was thought that these procedures could be rehabilitative and healing for inmates, in more recent times, these procedures are misused and overused and have been found to have many negative effects. Social isolation theory and sensory deprivation contribute to the reason on why these procedures affecting the mentally ill in such a drastic way. Those in solitary confinement, especially those with mental illnesses, do not receive the proper health care and mental health care that they need in order to be successful outside of the prison or institutional environment.

The comparing and contrasting of Mendota Mental Health Institute's and Montana State Hospital Forensic Mental Health Facility's seclusion and restraint policies showed differences in how these procedures are monitored by staff. While the two institutions had different time frames for monitoring an individual's placed into seclusion or restraints, they both focused on preventing re-traumatization or injury to the individual. Their policies also focused on making sure that staff assisting and monitoring these procedures were trained and knowledgeable on the procedures. The comparing and contrasting of the Wisconsin Department of Corrections, Louisiana Department of Corrections, and the Federal Bureau of Prisons policies on solitary confinement showed differences in how and when solitary confinement is used. It also showed that the institutions have different protocols for how inmates in solitary confinement are monitored and how they handle mentally ill inmates within these confinement settings.

Conclusion of Recommendations and Final Thoughts

The best way to prevent short term and long-term effects that were discussed relating to seclusion, restraint, and solitary confinement procedures, was to make sure that the policies that oversee them are able to manage their use. The following recommendations were made: (1) seclusion, restraint, and solitary confinement procedures should be used as infrequently as possible, (2) seclusion, restraint, and solitary confinement, when used, should be used for the shortest length of time possible, (3) the monitoring of seclusion, restraint, and solitary confinement should be consistent and adequate, along with being performed by well-trained and informed staff, (4) inmates with serious mental illnesses or those currently exhibiting symptoms of their illness should not be placed into solitary confinement unless it is an emergency situation, (5) when placed into seclusion, restraint, or solitary confinement, the inmate should not be placed in an environment of complete social isolation or sensory deprivation, and (6) long-term

solitary confinement should always be used for safety and security reasons with mentally ill inmates rather than as a form of punishment. With these recommendations, the policies that dictate and enforce the use of seclusion, restraint, and solitary confinement may become less harmful to mentally ill inmates and help to reduce their negative impacts over time. With the number of mentally ill individuals within the correctional population in the United States growing, it is important to address the issues and conditions that prison and institutional settings create for this population. By properly using seclusion, restraint, and solitary confinement procedures when managing mentally ill inmates within our correctional systems, there is a better chance of providing safe and secure environments for the mentally ill and the institutions that house them.

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