Commentary: The Use of Restraint and Seclusion in Correctional Mental Health

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In contrast to the position taken in the American Psychiatric Association's "Resource Document on The Use of Restraint and Seclusion in Correctional Mental Health Care," this commentary proposes limiting the use of mental health restraints to the stabilization of unsafe situations during the time it takes to transfer an inmate to a psychiatric hospital. Jails and prisons are inherently nontherapeutic environments and are not adequate settings for managing mental health emergencies, such as those that require the use of restraints. Correctional conditions often contribute to the onset, and impede the resolution, of the underlying mental health crisis. Attempts to contain mental health emergencies in a correctional setting with an expanded use of restraints can compromise clinical care, overlook the root cause of many crises, impair the role of mental health professionals by blurring the distinction between mental health and security staff, and can lead to a deterioration in the standards of care.

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The American Psychiatric Association's "Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care" (RD)[1] goes a long way toward providing reasoned guidelines in this area. The main question, however, is whether it goes far enough. In particular, I will address concerns regarding the use of seclusion and restraint as emergency interventions outside of hospital settings, except for circumstances that are more limited than those apparently endorsed in the RD. The more limited circumstances espoused herein consist primarily of an emergency intervention to maintain safety while arranging for an inmate's psychiatric hospitalization. Transferring an inmate to a hospital often takes time due to administration procedures, such as the need for prior court authorization in some states, and the need to prepare transport. Restraints can stabilize a dangerous situation during the time it takes to get the inmate patient to the hospital. This commentary also focuses on the use of restraints because, as the RD points out, the use of clinical seclusion is unusual in correctional infirmary settings, and other correctional settings typically lack the staffing or physical plant that the RD recommends for seclusion or restraint.

As Metzner points out in his introduction,[2] the number of inmates with serious mental illness has been rising steadily for many years. The population of these inmates in state and federal jails and prisons has long exceeded the number of patients housed in psychiatric hospitals. Correctional mental health programs are often the largest single mental health providers in their states. With so many patients housed in these settings, the need has never been greater for our profession to consider the standards that govern their care.

Although mental health care has become an increasingly central component of jail and prison management, the primary mission of corrections remains public safety, with a punitive component. Even the most enlightened correctional administrators find themselves reluctant caretakers of a growing number of inmates with serious mental illnesses. With perhaps rare exceptions, jails and prisons are not therapeutic environments. If anything, conditions in correctional settings often exacerbate the symptoms of inmates with serious mental disorders. A well-run institution with adequate clinical staff can provide

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structure and services for some inmates who would otherwise do without this support in the community, but this is more an indictment of the underfunding of community services than it is an endorsement of incarceration. As a class, however, mentally ill inmates fare more poorly than their inmate peers, including having an increased risk of sexual victimization while incarcerated,[3,4] and they are more likely to decompensate, receive disciplinary reports for rule infractions, and spend time in segregation units.[5–7] And despite the important role that correctional officers can play in mental health care,[8,9] they are not trained mental health professionals. Many officers do their best to provide compassionate supervision, but they have other responsibilities related to their security functions and they lack the mental health expertise and training of front-line staff in psychiatric facilities. It is also unfortunately true that a few officers behave with a style, and sometimes an intent, that can only be described as harmful to the emotional well-being of any inmate and toxic to inmates with serious mental illness.

As we develop treatment standards, those standards must reflect the harsh realities commonly found in jails and prisons and the detrimental effect that these settings can have on inmates with serious mental illnesses. The RD appropriately and accurately highlights these concerns. For example, the RD acknowledges the "importance of establishing a therapeutic culture to partner with the patient for safety" (Ref. 1, p 418) and correctly states that it is not clinically appropriate to use restraints in locked-down or segregation units, because these units "do not provide a supportive or therapeutic environment, and the environmental conditions often exacerbate the clinical condition of the inmate requiring seclusion or restraint" (Ref. 1, p 419). The RD, however, endorses restraint use not only in hospital settings but in infirmary or special housing units for mentally ill inmates as long as those settings have 24-hour nursing coverage.

The nontherapeutic nature of segregation, or even general population, units is readily apparent, but one might also wonder whether a prison-based infirmary or special housing unit is sufficiently therapeutic for the treatment of a mentally ill inmate in the midst of a mental health emergency. The physical environment of these units, along with their rules, regulations, security staffing, and culture is often significantly more correctional than clinical in nature. The ability to establish a sufficiently therapeutic culture within a prison unit, even a therapeutic prison unit, is simply too much to expect for the appropriate management of such extreme clinical circumstances. Prison mental health hospitals may encounter similar difficulties in their therapeutic mission, but at least they have the advantage of being structured as hospitals, with richer clinical staffing and with health care as the central component of their mission. Situations that require the use of emergency mental health intervention, such as restraints, are best managed in the most therapeutic setting available. A prison infirmary setting that equals the physical environment, staffing levels, clinical training, culture, monitoring, and performance-improvement activities that should be available in a prison psychiatric hospital might warrant a more expansive use of restraints. Because every correctional system should have hospitalization as an option, however, the most therapeutic setting will rarely, if ever, be an infirmary or a special housing unit.

The ability to apply therapeutic restraints without having to transfer an inmate to a hospital setting does, of course, have some advantages. For example, some inmates engage in self-injurious or severely disruptive behaviors that can place themselves and others at risk of harm. They may engage in these actions with identifiable goals that sometimes include attempts to get transferred out of segregation or other undesirable settings to a more pleasant hospital unit. Correctional and clinical staff may be loath to "reward" this behavior with its desired goal or to transfer the inmate to hospitals that may be less secure than the general prison or segregation units. In other instances, a relatively short period of restraints may stabilize some situations, thus avoiding the need for hospitalization.

The potential advantages, however, of an expanded use of therapeutic restraints in correctional institutions come with associated risks. In addition to clinical concerns about managing emergencies outside of the most therapeutic environment available, the risks of mental health restraints in a jail or prison include dilution of the focus from the root cause of the crisis, impairment in the role and effectiveness of mental health staff, and loosening of the standard of care. I address each of these risks in the text that follows.

Risks of Restraint Use

Inmates who require mental health restraints are almost always in mental distress, and clinical interventions should get at the root cause of that distress. In some instances their distress is due to a serious underlying mental disorder, such as clinical depression, mania, schizophrenia, or other affective and psychotic disorders. The root cause of distress in these emergency cases is best addressed in the intensive clinical environment of a hospital. In other cases, however, the distress may have situational origins. For example, some inmates experience significant distress when held in prolonged isolation in segregation-type settings. The distress can range from general dysphoria or unease to a more extreme syndrome that can include anxiety, panic, perceptual disturbances, dissociative symptoms, impaired concentration and memory, ideas of reference, feelings of persecution, hyperactivity, self-injurious behaviors, or aggressive fantasies and behaviors.[10]

Whether experiencing an extreme reaction or milder forms of distress, it is not uncommon, as already noted, for inmates in segregation to engage in self-injurious or disruptive behaviors for reasons that may include an effort to gain at least temporary transfer out of the segregation setting. The disruptive or self-injurious inmate in segregation who does not have an underlying serious mental disorder, or at most has an Axis II disorder, is all too often the most likely candidate for mental health restraints in a prison setting. In these cases, mental health staff frequently experience conflicting pressures to intervene and manage the behaviors without resorting to hospitalization. The only effective intervention for lasting symptomatic relief for such inmates, however, is modification of the conditions of confinement that are the root cause of their distress. Given this reality, is it appropriate to manage the traumatic reactions induced by prolonged and extreme segregation environments with a restricting and confining clinical intervention? How does this get at the root of the problem? Hospitalization at least provides a respite that often leads to rapid resolution of symptoms, along with a less pressured opportunity to review the situation with correctional administrators. For example, consideration can be given to mitigation of extreme environmental conditions that fuel the problematic behaviors. If the system is progressive enough to have special management units that combine segregation-type security with more humane programming and interpersonal activities, the inmate should be considered for transfer. Less enlightened systems, or those that simply lack adequate funding and resources, may instead find themselves with a cohort of aggressive inmates who bounce between secure, but clinically detrimental, segregation units, and clinically appropriate, but insecure, hospital settings.

Expanding the use of therapeutic restraint in a correctional setting also runs the risk of blurring the distinction between mental health staff and security staff, which can impair the role and effectiveness of mental health staff. Jails and prisons are inherently coercive environments. Inmates may be cuffed and shackled by security staff when transported or for other security reasons, and the same is true of segregation inmates whenever they come out of their cells. In contrast, the paradigm for interaction with mental health staff is one of negotiation and building therapeutic alliances. As a general rule, psychiatrists do not force treatment on patients. Barring rare emergency exceptions, clinicians have a duty to obtain informed consent, even from inmate patients. Prison medical and mental health units are often noncoercive islands of negotiation and shared decision-making within an otherwise coercive correctional sea. We have cause for concern about the effect that an expanded use of therapeutic restraint might have on clinical dynamics.

Although similar concerns can certainly be raised about using restraints in a psychiatric hospital setting, the psychological consequences may be of greater importance in a general prison. Most inmates will spend a much larger portion of their incarceration in a prison rather than in a hospital, and anything that affects attitudes toward treatment outside of the hospital can be especially significant. As noted, interactions with mental health professionals may be one of the rare opportunities that inmates have for fuller empowerment. An expanded use of mental health restraints within an environment that inmates already experience as authoritarian, restrictive, and coercive may compromise the ability of inmates to perceive clinicians as operating within a different model. This perception cannot be good for building trust and therapeutic alliances. None of the foregoing points should be construed as a wholesale argument against the use of therapeutic restraints, which are sometimes necessary to prevent serious harm. Nevertheless, the potential for contamination of the

unique and important clinical role in a jail or prison suggests a more limited and cautious use in those settings.

The final concern addressed here regarding the use of restraint in prison involves the risk of loosening of the standards of care. The modifications to these standards proposed in the RD show that this risk is real and manifest, not just theoretical. For example, the RD states that "[w]hen an inmate is secluded or restrained in a hospital setting, the rules promulgated by CMS should be followed" (Ref. 1, p 419), but the RD does not explicitly endorse following the Center for Medicare and Medicaid Services (CMS) rules in nonhospital correctional settings. The "major departure" endorsed by the RD from the CMS guidelines involves the time parameters for assessment of inmates in seclusion and restraint. Loosening the time requirements is a tacit recognition that clinical staffing in corrections will not allow for the hospital level of assessment and supervision. This is a realistic, but telling, concession. If anything, however, correctional facilities should be held to a higher standard because of their coercive and nontherapeutic environments. The fact that meeting CMS timeframes is not practical warrants heightened caution. Instead of loosening prevailing standards to accommodate the realities of jail and prison resources, our patients might be better served by acknowledging the inappropriateness of using extreme interventions in substandard settings, except in the most unavoidable circumstances.

Restraint Use in Nonhospital Settings

Despite its occasional departure from guidelines, the RD appropriately states that correctional health care systems "should be held to a similar standard of care as community health facilities" (Ref. 1, p 418) when they use seclusion or restraint. Many, if not most, nonhospital community facilities, however, do not use restraints. The reasons for this may include a lack of legal authorization, a voluntary and noncoercive treatment philosophy, or a recognition that nonhospital settings are not staffed or equipped to handle clinical emergencies that require higher intensity services and staffing such as those found in emergency rooms or inpatient units.

Endorsing restraint use in nonhospital correctional settings that is widely eschewed in nonhospital community settings stretches community standards and has risks. The prevailing lack of effective and meaningful oversight of correctional restraint use only compounds these risks. The RD points out that "the rules established by CMS concerning the use of restraint and seclusion had little impact on use for mental health care purposes in correctional systems" (Ref. 1, p 418) and that "many correctional health care systems have not developed policies, procedures, or practices that are consistent with the current community practice" (Ref. 1, p 418). These deficiencies are exacerbated by "the frequent lack of meaningful external review or oversight" (Ref. 1, p 418) of mental health practices in corrections and by the fact that standards proposed by correctional health care accreditation organizations such as the National Commission on Correctional Health Care[11] provide "little guidance." It may be overly optimistic to assume that the RD will succeed where other guidelines have failed. Recommendations in an APA RD may have limited impact beyond the fact that they endorse the use of seclusion and restraint in correctional settings. Many correctional administrators will pay little heed to the specific recommendations in the RD. Thus, the dangers of loosened standards are compounded by the likelihood of less effective oversight of restraint practices in jails and prisons.

Conclusions

As a former clinical administrator with almost nine years of experience overseeing mental health services in a state prison system, I offer this commentary not without reservation. I appreciate all too well the pressures that are often brought to bear on clinicians and clinical administrators who work in corrections. I also understand the potential convenience, if not advantages, that may exist in being able to use therapeutic restraints as more than just a temporary safety measure before hospitalization. I appreciate, however, the professional responsibility that goes along with our knowledge and privileges.[12] We have an unsurpassed ability to speak with credibility and authority on behalf of the needs of inmates with mental disorders or in mental distress. The struggle for adequate community resources that might keep some patients out of the criminal justice system in the first place is itself a daunting task. But as we follow a growing number of our patients into the jails and prisons, we should behave a little less as guests in the houses of corrections.

Our patients, and we along with them, appear to have taken up permanent and central residence in

correctional facilities. As a result, we can and should have a strong voice in the care and management of mentally distressed inmates. Someone must advocate on behalf of the clinical needs of the patient, and if not us, who? The challenge, of course, is to find a reasoned voice. I believe that we can do this only by openly debating difficult questions, such as the one regarding the use of restraint and seclusion.

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