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Health and Well-Being in Prison Context

Abstract

This study aims to investigate the effects of solitary confinement on an individual's physical and mental health and quality of life. Twenty-three hours confined in hollow singular cells, limited access to fresh air and natural light, and a close control is the common idea of solitary confinement. Data on the negative effects of prisons on inmates' social life, rehabilitative capacities, well-being and health, combined with the lack of transparent information on solitary confinement and supermax prisons, has led to the development of this study, including peer reviewed documents over the last 23 years with empirical research and any correlation with the effects of prison on the adult inmate in solitary confinement. Mental symptoms have been increasing among prison population over the years and were greater than the physical ones, including depression, anxiety, psychological distress, post-traumatic stress disorder, and a multiplicity of personality traits and clinical syndromes. Self-harm and suicide attempt rates were equally alarming. Some quality-of-life aspects include: lower levels of education, an average of 12 months in solitary confinement and higher rates of violence. A higher probability for placement in solitary confinement for those with a previous mental disorder diagnosis. Any time spent in solitary confinement also increased the odds for physical or mental conditions. Moreover, the effects of solitary confinement on the prisoner's health and quality of life are unjustified, as the sentence should only restrict the inmate of his freedom, calling for practical data. We recommend that this line of research be further developed.

Keywords: health, prison, solitary confinement, quality of life, well-being

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Introduction

Solitary confinement involves placing a prisoner in a room with restrictive and minimal conditions for 22 to 23 hours a day, having 1 to 2 hours of outdoor exercise or other activity, whenever appropriately supervised, and without contact with other prisoners. Although the conditions and restrictive measures of this front of segregation varies from country to country, the constant idea of confinement is that of a sparsely furnished cell, with limited access to natural light and fresh air, and little to no view of the outside world, confined to a totally artificial environment where they are constantly and closely observed and controlled, with minimal and superficial interactions with staff, with an even higher level of dependency than is normally the case in the general prison population (Shalev 2008). The increase in the use of solitary confinement for prolonged periods of time in maximum security prisons has led the scientific community and critical elements of society to question the legality and constitutionality of this practice as a cruel and unnecessary punishment, such as: the ethics behind the permissibility of radical isolation; clinical questions about the psychological effects of prolonged isolation; social questions about the rationalisation of crime, among others (Guenther 2011).

Most jurisdictions, as for the United States of America, have limited the use of solitary confinement to violations of specific prison rules and for short periods of time. In contrast, the use of solitary confinement in maximum security prisons differs in several important respects, most notably in the extent of isolation, the perceived duration of isolation, the reasons for its imposition and the technological sophistication with which it is achieved. When inmates in these units are escorted out of their cells or beyond the prison units in which they are housed, they are typically first placed in restraints, chained while still in their cells. They are rarely, if ever, in the presence of another person (including doctors and physical therapists) without a variety of physical restraints. Prisoners in maximum security prisons are usually severely restricted in the type and amount of personal property they may possess and in their access to the prison library, court materials and canteen (Haney 2003). Deprived of daily human contact and confined to a space with very little stimuli, it is natural for any individual to feel disconnected from reality (Guenther 2011).

Solitary confinement is subject to greater legal scrutiny and should be the subject of rigorous scientific research (Naday et al. 2008). There is clear evidence that solitary confinement has a profound impact on health and well-being, particularly for those with pre-existing mental disorders, and that such confinement can also actively cause

mental disorders. The extent of this harm at the psychological level varies and depends on individual factors, the environment, the regime in which they are placed, and the context and duration of their isolation (Shalev 2008).

Therefore, the aim of this study is to gain a better understanding of the effects of solitary confinement on the well-being and health, both mental and physical, of prisoners, whether in maximum security prisons or not.

Solitary confinement effects on mental health

We tried to review studies of solitary confinement in prisons, whether maximum security or not, in order to answer the guiding question: "What are the effects of solitary confinement on an individual's physical and mental health?"

Reiter et al. (2020) carried out a longitudinal study with the aim of verifying the prevalence of symptoms and measurements of psychological stress among prisoners in long-term solitary confinement. The authors found similar levels of depression among inmates in solitary confinement and lower levels in the general prison population. Analysis of individual inmate files reveals that 19% have diagnoses of severe mental disorder, 22% had a documented suicide attempt and 18% had documentation of other self-harm, either during their incarceration or during their time in solitary confinement. Participants in the study also mentioned other symptoms such as sensory hypersensitivity (16% of respondents mentioned this at least once) and loss of identity (25% of respondents mentioned this at least once).

For their part, Valera and Kates-Benman (2016) carried out a study using 110 participants aged between 35 and 67 who had been in solitary confinement. The results of the study indicate that around 40% of the individuals have already used mental health services, as well as the existence of a risk of being assaulted by other inmates. More than half were also at risk of being assaulted by prison guards. 15 individuals (14%) with experiences of solitary confinement reported attempting suicide during this period, yet the overwhelming majority (70%) said they felt "safe". The majority of men spent an average of 2 years in solitary confinement. In their study, Valera and Kates-Benman (2016) also used qualitative interviews with 30 of these participants to explore their experiences during their time in solitary confinement. The interview responses fell into three categories. First, the use of solitary confinement as punishment stands out. In this sense, participants reported feeling punished by being subjected to conditions similar to military conditions and treatment. Second, the interviews revealed that the

first experience of solitary confinement is more difficult for participants because they do not know what to expect. For example, participants mention that life in solitary confinement units is initially "hard" because of the severe restrictions on their freedoms, but is acceptable after a period of adjustment. Finally, although most of the men had experienced punishment and had difficulty adjusting while in solitary confinement, some participants noted that they preferred being in solitary confinement to being in the general prison population, saying that it allowed them to find a certain peace of mind by allowing them to avoid problems such as violence, stress, "meaningless things" and "smells" created by living and interacting with other inmates.

O'Keefe (2007) found that women were more likely to have mental health problems than men, but were less likely to be allocated to administrative segregation. Criminal history and institutional behaviour were useful variables for distinguishing inmates in administrative segregation from those in the general prison population. It was also noted that inmates in administrative segregation were more violent and more involved in security threat groups, and had more disciplinary infractions, and more moments of punitive segregation than inmates in the general prison population. Inmates with mental disorders in administrative segregation showed a higher risk of recidivism, as measured by the LSI-R, following those with mental disorders in the general prison population and those without mental disorders in administrative segregation; for their part, inmates without mental disorders in the general prison population had the lowest scores. Using logistic regression, O'Keefe (2007) found that membership of violent groups appears to be the best predictor, being four times more likely than other inmates. Violent behaviour, being a man with a mental disorder and being Hispanic were also identified as risk factors, even when this last factor was controlled for using other variables, such as belonging to a gang.

In a second study, O'Keefe (2008) found that inmates in administrative segregation were more likely to be male, Hispanic and younger than the general prison population. Prisoners in administrative segregation were more likely to be serving a sentence for a violent crime than the rest of the prison population. Although they did not have higher recidivism rates than the general prison population, the results indicated that they had been institutionalised for longer periods. Similarly, O'Keefe (2008) found that inmates in administrative segregation were 7 times more likely to have been sanctioned prior to administrative segregation. The percentage of inmates in administrative segregation with a mental disorder (25%) substantially exceeded that found in the general prison population (16%), and they also had higher total BPRS scores than the rest of the general prison population. The author also found that, after

entering prison, those inmates who showed schizoid, narcissistic, antisocial, aggressive, passive-aggressive, schizotypal, borderline personality traits or delusional thoughts were more likely to be subsequently placed in administrative segregation.

Likewise, Mears et al. (2021) found that, compared to the general prison population, inmates in prolonged solitary confinement had unique values in almost all dimensions. Men were more often placed in solitary confinement. Mears et al. (2021) found that adolescents and young adults, as well as individuals with mental health problems, were more likely to be placed in prolonged solitary confinement. Substance abuse was slightly higher in the solitary confinement population (46%) compared to the general prison population (40%). For their part, the educational qualifications of prisoners in solitary confinement were lower when compared to the rest of the prison population, but the recidivism rate was lower, which can be explained by the higher percentage of individuals convicted of violent crimes. The profile of individuals placed in prolonged confinement in the first 6 months after incarceration was even more likely to have been in a mental health unit or to have needed outpatient treatment with medication. The consistent pattern across all models of prolonged solitary confinement is that mental health needs predict placement in prolonged solitary confinement just as much as placements in confinement at the start of incarceration and those of longer duration.

For their part, Campagna et al. (2019) developed a longitudinal study with 408 inmates in 3 different time periods who were on state supervision, focusing on how isolation and protective factors affect the inmate's intervention needs, including mental health. They concluded that the number of days in solitary confinement was negatively and significantly associated with mental health, with a 1.7% reduction in the likelihood of receiving a higher mental health score for each day in solitary confinement. The number of days in lockdown did not prove to have a bearing on the propensity to change, but being homeless could decrease this score by 57%. In addition, some variables such as incarceration rate, age, juvenile crime, homelessness and gang affiliation significantly reduced the likelihood of the individual being able to maintain a positive mental health state. However, respect for authority and impulse control did not vary. The number of days in confinement negatively affected behaviour towards an authority figure, with a 2.4% reduction in the likelihood of exhibiting appropriate behaviour towards this figure, but was not related to greater impulse control on the part of the inmate. In addition, being homeless was associated with a 50% reduction in impulse control scores, but completing secondary school managed to increase these scores by 150%. Participation in vocational programs improved propensity to change

scores, with a 0.4% increase in this variable for every hour. Unfortunately, no variable was related to an increase in positive mental health status.

Finally, Hagan et al. (2018) conducted a longitudinal study linking solitary confinement with symptoms of post-traumatic stress disorder in recently released inmates. The majority of the 119 participants in solitary confinement were male (85%), non-Hispanic black (51%) or Hispanic (34%), with an average age of 44 and temporary housing (85%). The reason for being held in solitary confinement was disciplinary action (73%), with 42% being held for between 1 month and 1 year, and 12% for more than 1 year. Many of them had mental health problems (42%), a previous PTSD diagnosis (17%), and had used substances throughout their lives (66%). However, none of these factors differed between those with and without a history of solitary confinement. Comparing their sample with individuals with no history of lockdown, the authors found that 28% of the participants had PTSD symptoms. However, those individuals with a history of lockdown were more likely to report PTSD symptoms than those without, and a history of solitary confinement and chronic mental health conditions were highly associated with a PTSD assessment.

Hagan et al. (2018) proceeded to exclude participants with a previous PTSD diagnosis to eliminate the effect of this variable. However, PTSD symptoms remained more common among those individuals who had been in solitary confinement. Thus, the authors concluded that there is a relationship between PTSD symptoms and solitary confinement, but only among those individuals who do not have a history of chronic mental illness.

Solitary confinement effects on physical health

If there are few studies carried out in prison contexts that address the influence of a prison stay on physical health, there are even fewer that have been carried out during solitary confinement.

Williams et al. (2019) conducted a study in a maximum security prison with the aim of analysing the relationship between cardiovascular disease and the increased prevalence of hypertension diagnosis in people in solitary confinement, using inmates from the general prison population as a comparison group. The authors found that because inmates in solitary confinement experienced a higher prevalence of hypertension than those in the maximum security wing, about one-third may experience this higher burden associated with cardiovascular disease and cost. The authors concluded that

the diagnosis of hypertension persists throughout life, with individuals in prison and in the community experiencing the same control and cardiovascular effects of hypertension. The focus was on hypertension-related cardiovascular diseases and other possible conditions/problems caused or aggravated by solitary confinement were not considered, suggesting that the analysis underestimates the overall impact of solitary confinement on health and other associated consequences.

Strong et al. (2020) examined the relationship between solitary confinement and physical health problems, as well as the health disparities associated with incarceration. To this end, they used a sample of 106 men who had been in solitary confinement for long periods of time. In general, no differences were identified between the sample used and a comparison sample in solitary confinement (who had been in solitary confinement for a shorter period of time), but in relation to the general prison population, the latter being less violent, serving shorter sentences, and less likely to be affiliated with gangs, which the authors associate with the fact that the prison population has a higher average age, and there is a lower percentage of Hispanic individuals among the general prison population. Strong et al. (2020) assessed participants repeatedly and found a persistence of somatic problems over the course of a year, although no statistically significant relationships were found in the variables analysed. Regarding health disparities in the prison population, they identified health problems in 63% of the participants, 48% of whom were taking medication, 17% had arthritis and 8% experienced a relapse during confinement, associating physical symptoms with both deprivation conditions and deprivation policies limiting access to health services, including chronic musculoskeletal pain exacerbated by the intersection of deprivation conditions and policies.

Discussion

In view of all the databases from which articles and documents were extracted, and observing the small number of studies that focus in some way on the effects of solitary confinement on the physical and mental health of prisoners or that comment on it directly or indirectly, the conclusion drawn in the first instance is precisely the small number of empirical studies observed, as well as the need to develop more research studies on the subject.

There are many effects of solitary confinement on the prisoner's health and quality of life, and this is not only related to deterioration and the possible development of adverse health conditions, as the diagnosis of mental disorder itself also indicates

a greater propensity for the prisoner to be placed in solitary confinement. We therefore need to consider the necessity and ethics of this resource, as well as the effects it has on the population it is used on. On a practical level, more contact with the outdoors, more time for recreational activities would be good practices that, despite the prisoner having to be "punished" for any previous infractions, this punishment should not seriously harm the prisoner's well-being or their health, physical or mental.

The diagnosis of mental disorders, as well as the effects on the prisoner's physical condition, would only contribute to a reduction in their quality of life, both in the short and long term, which is unjustified once the sentence is applied for the sole purpose of restricting their freedom. Since this restriction, in a more virile and difficult-to-adapt format, can generate or hasten symptomatic preconditions, other methods should be taken to ensure that this does not happen. More practical studies are required to increase the database that will allow us to indicate with certainty the existing effects of solitary confinement on prisoners, especially in terms of their quality of life, which is interlinked with mental and physical health.

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