Labor in Chains:

The Shackling of Pregnant Inmates

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In the United States, incarcerated pregnant women are often shackled by correctional officers. Despite being prohibited during labor and delivery at the federal level, and in 22 states and the District of Columbia, perinatal shackling remains standard operating procedure in most correctional facilities. A number of factors contribute to the continuation of this practice even in jurisdictions where it is illegal, including poor implementation of laws banning shackling, lack of training for individual correctional officers, and perpetration of stereotypes about what makes a "good" or "bad" mother. This article reviews the history of the practice of shackling pregnant inmates, assesses the current state of affairs of this practice, examines the arguments for and against perinatal shackling, and analyzes the presumptions that allow it to continue. It then explores several alternatives to shackling along with prospects for change.

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INTRODUCTION

Pregnant women often are often shackled while behind bars, including during labor and delivery of babies. With roughly six to ten percent of female inmates pregnant at admission, this issue affects over 6,500 women nationwide (Thomas and Lanterman 2017). As the number of female inmates has increased nearly tenfold over the past four decades (Law 2015), if current incarceration trends continue this problem will only grow.

Historically, prisons have been designed by men, and the rules that govern treatment of inmates were predicated on a male population. These rules were then applied to women's prisons without considering their distinct needs. Presumably, prison authorities shackle pregnant inmates in labor because they do so for all inmates when providing medical care. In this way, "practices that are theoretically gender-neutral," such as shackling, "impose gender-specific indignities on female prisoners" (Ahrens 2015). Prisons have administered this rule without considering the unique stresses and dangers of pregnancy and childbirth for women, leading to the medically contentious practice of shackling pregnant inmates.

Beyond the practice of shackling, it is important to also examine where these "gender-specific indignities" come from and how they operate as part of US society. This article presents a timeline of the shackling of pregnant inmates, examines the current state of affairs, explores the arguments for and against shackling, and analyzes the frameworks and origins of the stereotypes that are key in allowing this practice to continue. It then explores several alternatives to shackling and discusses the prospects for policy change moving forward.

DEFINITION OF TERMS

Shackling is defined as the use of "any physical restraint or mechanical device to control the movement of a prisoner's body or limbs, including handcuffs, leg shackles, and belly chains" (American College of Obstetricians and Gynecologists [ACOG] 2011). Among pregnant inmates, perinatal shackling—which occurs in the weeks leading up to and after giving birth—is the most controversial form. Other, more specific, terms used throughout this paper include: prenatal (referring to any time before birth), antepartum (shortly before birth, usually the third trimester), intrapartum (during birth), and postpartum (after birth). Perinatal and intrapartum shackling, for example, often entail chaining the ankles and/or wrists of pregnant women to a hospital bed (Dignam and Adashi 2014).

RECENT LAWS AGAINST SHACKLING

Prisons have long shackled both male and female inmates while they receive medical care. Legal scholars argue that these policies "hearken back to an era when convicted women were considered morally subhuman" and that prisons have long disregarded the specific needs of female prisoners (Doetzer 2008). Resistance to the practice of shackling pregnant inmates has grown in recent years but the practice was not officially banned in any state until 2000. That year Illinois became the first state to do so, passing a law prohibiting state prisons from shackling inmates during pregnancy except in extraordinary circumstances (American Civil Liberties Union [ACLU] of Illinois 2011). Since then, other states have followed, enacting

new laws, issuing formal recommendations, and altering corrections department policies about shackling pregnant inmates. By the start of 2018, in addition to Illinois, 21 states and the District of Columbia had outlawed the practice: Arizona, California, Colorado, Delaware, Florida, Hawaii, Idaho, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Pennsylvania, Rhode Island, Texas, Vermont, Washington, and West Virginia (see Appendix A). In 2015, roughly half of all female prisoners in the United States were incarcerated in jurisdictions where such shackling has been outlawed. In 19 states, the practice is not illegal but is contrary to official corrections department policy. Corrections department policies often do not match the recommendations of medical and advocacy organizations, and many do not contain reporting requirements or consequences for nonadherence (Fienauer et al. 2013, Thomas and Lanterman 2017). Over 30 percent of these states do not publish their anti-shackling policies (Fienauer et al. 2013).

Meanwhile, new laws and court decisions have ushered in major reforms at the federal level. In 2007, the U.S. Marshals Service released official policies and procedures regarding the use of restraining devices in federal correctional facilities, mandating that prisons not shackle pregnant women during or immediately after labor or delivery (ACOG 2011). The following year, President George W. Bush signed the Second Chance Act into law, requiring the documentation, reporting, and justification (on security grounds) of all uses of physical restraints on pregnant inmates by federal correctional facilities (Dignam and Adashi 2014). Further, the law required the Attorney General to report to Congress on the policies and practices of Department of Justice agencies regarding the physical restraint of female inmates at any point during pregnancy, delivery, or postpartum recuperation (Dignam and Adashi 2014). The same year, the Federal Bureau of Prisons updated its policy to ban correctional officers from shackling pregnant inmates during labor, delivery, or postpartum recuperation, barring reasonable belief that the inmate poses an imminent threat to herself or others or is a credible and immediate flight risk that cannot be subdued in any other way (Dignam and Adashi 2014).

In 2009, the US Court of Appeals for the Eighth Circuit reached a landmark decision regarding shackling in Nelson v. Correctional Medical Services. Using the Supreme Court precedent that "either interference with care or infliction of 'unnecessary suffering' establishes deliberate indifference in medical care cases in violation of the Eighth Amendment," the judges in Nelson found that the shackling of pregnant inmates was unconstitutional, violating the Eighth Amendment right to freedom from cruel and unusual punishment (Nelson v. Correctional Medical Services, 583 F.3d 522, 532 (8th Cir. 2009)). As a federal circuit court, this precedent is binding in all federal courts in the circuit and highly persuasive in the state courts within the circuit (Gilley 2016). However, of the seven states in the Eighth Circuit, only Minnesota has a statewide ban on shackling; five others have correctional department policies against shackling pregnant inmates, leaving Nebraska as the only state in the Eighth Circuit to have no official guidance on the subject (see Appendix A).

CURRENT STATE OF SHACKLING IN US PRISONS

The federal policies outlined above work together to either ban or severely restrict the shackling of pregnant inmates at the federal level. Though the enforcement of federal protections is imperfect, as of 2015 federal prisons only house 13 percent of the incarcerated population in the United States, about 13,000 women (Carson and Anderson 2016). For this

reason, the discussion that follows will focus on state-level institutions, which held just under 100,000 incarcerated women in 2015 (Carson and Anderson 2016).

As of 2017, in the 28 states without shackling restrictions, perinatal shackling remained standard operating procedure. However, even in the states that restrict the practice, some facilities continue to use shackles on pregnant inmates, largely the result of uneven implementation of shackling bans and poor dissemination of information and training for correctional staff.

In 2012, Cook County Jail in Illinois agreed to pay a $4.1 million settlement in a suit brought by 80 women who claimed they had been shackled while giving birth (Mastony 2012). In 2015, a report from the Correctional Association of New York revealed that 23 of 27 women interviewed—who had all given birth while incarcerated since the state ban was passed—claimed that they were shackled during delivery (Correctional Association of New York 2015).

In Wisconsin, a state that has not banned shackling, 46 women who allege they were shackled during labor are assembling a class-action lawsuit against the Milwaukee County Jail, a case that could lead to a state ban (Nelson, 583 F.3d). These women were shackled when the police department was led by Sheriff David Clarke, who has argued that shackling prevents escape and protects hospital staff and guards (*Nelson*, 583 F.3d).

ARGUMENTS FOR SHACKLING

Correctional facilities use two primary arguments to justify the practice of shackling pregnant inmates. The most prevalent holds that shackling ensures the safety of corrections officers, health professionals, and inmates themselves. This idea arises from the fear that an unrestrained inmate will lash out and harm those around her, particularly civilian health professionals. The other main justification is to prevent the inmate from escaping while receiving medical care (Doetzer 2008). As many prisons send inmates to contracted civilian hospitals that are less secure than correctional facilities, prison staff might worry that inmates will see a trip to the hospital as an opportunity to escape.

On closer inspection, these arguments are not supported by the evidence. First, most incarcerated women—63 percent at the state level, and 96 percent at the federal level in 2016—are nonviolent offenders (Carson 2018). Prison authorities often fail to consider the individual inmate's history of violence or escape attempts when determining whether or not to shackle her, and assume that pregnant women pose the same security threat and flight risk as other female inmates who are not pregnant (Dignam and Adashi 2014). Second, it is dangerous and difficult for a pregnant inmate to attempt escape. With the extra weight, shifting center of gravity, and physical exhaustion that often accompanies pregnancy and especially labor, pregnant female inmates who attempt to escape from a hospital are unlikely to get very far. Of the thousands of pregnant prisoners who have been transported unshackled to medical treatment, only a handful are known to have escaped police custody; all were found or turned themselves in within several hours. No prisoner has been unshackled and known to have attempted to escape before, during, or after childbirth (ACOG 2011).

ARGUMENTS AGAINST SHACKLING: LEGAL

Several courts have ruled that shackling pregnant inmates violates the Eighth Amendment of the Constitution, which bans "cruel and unusual punishment." In the landmark case of *Estelle v. Gamble* in 1976, the Supreme Court ruled that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain'… proscribed by the Eighth Amendment," a precedent used in many cases that followed (Estelle v. Gamble, 429 U.S. 97, 105 (1976) (quoting Gregg v. Georgia, 428 U.S. 153, 173 (1976)).

The next pivotal case came almost two decades later with the 1993 class-action lawsuit, *Women Prisoners of District of Columbia Department of Corrections v. District of Columbia*. The US District Court for the District of Columbia held that shackling a woman while in labor or immediately postpartum is inhumane and violates the Eighth Amendment (Women Prisoners of District of Columbia Department of Corrections v. District of Columbia, 877 F.Supp. 634 (D.D.C.1994)). The following year, in *Farmer v. Brennan* the Supreme Court found that the "failure to protect" an inmate from harm by refusing or obstructing medical treatment also violates the Eighth Amendment (Farmer v. Brennan, 511 U.S. 825, 831 (1994)).

In 2009, the court in *Nelson v. Correctional Medical Services* concluded that prisoners have the constitutional right not to be shackled unless they present a serious and immediate security or flight risk, and that prison officials are "deliberately indifferent" if they knowingly disregard a significant risk to a prisoner's health or safety or a serious medical need (*Nelson,* 583 F.3d). The next year, in *Brawley v. State of Washington*, a federal district court pointed to Nelson as precedent, ruling that the shackling of inmates during labor clearly violated the Eighth Amendment's prohibition of "cruel and unusual punishment" (Brawley v. State of Washington, 712 F.Supp.2d 1208 (W.D. Wash. 2010)).

ARGUMENTS AGAINST SHACKLING: MEDICAL

Medical practitioners have also made a strong case against the practice of shackling pregnant inmates, pointing to the physical complications that can arise as a result. These issues fall into three categories based on when they occur: antepartum, intrapartum, and postpartum. In the antepartum period, shackled pregnant women are more likely to fall due to their shifting center of gravity, and wrist constraints may inhibit their ability to break the fall or avoid falling directly on the stomach, potentially harming the fetus. In addition, by constraining movement, shackling makes it more difficult to identify and test for the causes of many pregnancy complications, including appendicitis, kidney infection, preterm labor and vaginal bleeding. Any delay in diagnosing these conditions, especially vaginal bleeding, can pose a threat to the lives of mother and baby (ACOG 2011). Further, hypertensive disease occurs in approximately 12 to 22 percent of pregnancies, accounting for around 8 percent of maternal deaths in the United States from 2011 to 2013 (ACOG 2011, Creanga et al. 2017). These and other conditions, including preeclampsia and hypertensive disease, can lead to seizures in pregnant women, which can be extremely difficult to treat in a timely manner when the patient is shackled.

In the intrapartum period, shackling poses threats and adds further discomfort to an already painful experience. During labor, obstetricians generally recommend walking and

maternal repositioning to accelerate labor and relieve pain (ACOG 2011). If a patient is shackled to her hospital bed, the attending practitioner cannot follow either recommendation. Further complications may arise during epidural administration, which becomes much more difficult when women are chained and forced to lie on their backs. This constrained position can also undermine safe delivery in cases with complications. Intrapartum shackling can be particularly dangerous should the doctor need to rapidly transition to a Caesarean section (ACOG 2011). Overall, shackling significantly interferes with medical treatment at every point during labor and delivery.

After a patient has given birth, the possibility of serious postpartum medical complications remains. Doctors highly recommend walking to prevent many dangerous post-delivery complications, such as deep vein thrombosis; however, this preventative measure is not possible if a patient is chained to her hospital bed after delivery (American College of Chest Physicians 2012).

FRAMEWORKS AND ORIGINS: CONSTRUCTION OF "GOOD" AND "BAD" MOTHERS

The lens through which society views pregnant inmates has important implications for their treatment; differences in perception can directly result in differential treatment. These critical differences are often the result of social constructs. In this case, the constructs of "good" and "bad" mothers are especially influential. These constructions tend to evolve alongside society, shifting to fit the norms of the time.

In particular, the War on Drugs has reshaped what constitutes a bad mother through the criminalization of certain actions taken during pregnancy. As of 2015, 45 states prosecuted women for alcohol abuse or substance abuse while pregnant, though most states do not explicitly prohibit drug or alcohol use during pregnancy (Miranda et al. 2015). Instead, the criminal justice system seeks to punish mothers thought to be endangering their fetus by applying loose interpretations of other laws, such as those against child abuse or delivery of drugs to a minor (Luna and Luker 2013). In pursuing mothers who may be using drugs or alcohol during pregnancy, the corrections system seeks to "detain, confine, or incarcerate" these "unfit" mothers (Luna and Luker 2013). As Kilty and Dej (2012) explain:

> Popular media, legal, and correctional discourses construct drug-using women as transgressors of both the law and the normative standards of femininity, which includes essentialized notions of motherhood, because of their criminality and substance use… These discourses seemingly construct a binary of "good" and "bad" mothers, and fail to consider socioeconomic, political, and structural disadvantages that can have harmful implications for women involved in the criminal justice system.

Kilty and Dej go on to suggest that this false dichotomy negatively affects incarcerated women in two ways. First, female inmates engage in self-surveillance and then compare

themselves to the idealized archetype of the perfect mother, resulting in damage to their sense of self-worth. But this self-criticism is often far less harmful than the judgment of correctional officers, who are likely to compare inmates to the mothers in their own lives, despite the very different socioeconomic and political contexts shaping the lives of incarcerated women. Stereotypical thinking emerges as a result, further reinforced by the fact that "correctional programs rely on normative understandings of motherhood and thus fail to account for the context within which these relationships exist" (Kilty and Dej 2012). This can lead correctional officers to judge and shame the pregnant inmates they perceive as bad mothers—and punish them accordingly.

PUNISHED FOR BEING PREGNANT?

These elements of surveillance and judgment apply to nonincarcerated women as well. Scholars Zakiya Luna and Kristin Luker (2013) note that poor women of color are far more likely than white or middle-class women to undergo surveillance in their daily lives because of their disproportionate use of publicly funded services. These women "experience increased surveillance of behaviors that women with more class privilege could largely hide from their private doctors," such as drug and alcohol use during pregnancy (Luna and Luker 2013). This increased surveillance is a large part of why many pregnant women enter the criminal justice system.

The same constraints and challenges faced by demographically similar incarcerated and nonincarcerated women illustrate that the treatment of pregnant women in these demographic groups is linked to "patterns of racial, ethnic, and class distrust" within the criminal justice system, medical establishment, and other institutions (Ahrens 2015). Further, law professor Deborah Ahrens (2015) argues that "the constraints and indignities imposed on pregnant prisoners are an outgrowth not only of patterns of social control of prisoners but also patterns of social control of pregnant women more generally." Ahrens theorizes that pregnant women in jail suffer in these specific ways as punishment for pregnancy as well as for any actual crime committed. Incarcerated women "are [first] marginalized because of their demographics and then remarginalized by their very construction as 'criminals' or 'prisoners'" (Ahrens 2015). This intersection of marginalized identities is what makes incarcerated pregnant women inherently vulnerable to the negative effects of practices such as shackling.

ALTERNATIVES TO SHACKLING

Despite the strong legal and medical arguments against shackling pregnant inmates, the practice persists. Obstacles to change include the uneven distribution of information to and training of prison wardens, correctional officers, and medical staff, dominant stereotypes of pregnant inmates as unfit mothers deserving punishment, and criminal justice policies designed by men for men.

There are, however, several viable alternatives to shackling for these women. Pregnant inmates who pose a flight risk are very rare and in most states, armed guards are posted outside of hospital rooms to ensure that inmates do not escape. Due to the medical complications

associated with pregnancy, a woman about to give birth or who has just given birth is unlikely to voluntarily remove herself from medical care.

Violent pregnant inmates are also rare, but the construction of the "bad" and even dangerous mother distorts how correctional staff see and respond to them. In addressing the outlier of a pregnant inmate who poses a threat to herself and others, correctional officers and medical staff can use soft restraints instead of handcuffs and only restrain the hands, unless there is a legitimate threat to safety that necessitates restraining the legs. If needed, staff can also use soft restraints on the legs, and officers can defer to the medical staff present and the comfort of the inmate in making the decision to restrain further. If shackled, staff can allow the inmate to change position as required for comfort or medical attention, as complications may arise from restricted movement.

Several states that have passed shackling bans have now updated them to make further changes. In New York, an updated 2015 law dictates that correctional officers must remain outside the birthing room unless their presence in the room is specifically requested, a measure intended to bring comfort to the patient and ease the birthing process. This law also requires rigorous training on the policy for staff and mandates reporting of all instances in which shackling is deemed necessary (Correctional Association of New York 2015).

In Illinois, the first state to pass a shackling ban, many alternatives have been tested. When the state first banned shackling during labor, it found that many counties, including Cook County as mentioned above, were not following the policy. In 2010, the state amended its ban to read that only handcuffs could be used on pregnant prisoners, not leg irons or belly chains. Less than a year later, the policy was amended again to mandate that no restraints be used on a pregnant woman at any point unless she poses a flight or security risk (Mastony 2012).

POTENTIAL DEVELOPMENTS

In 2017, four US senators introduced the Dignity for Incarcerated Women Act of 2017, also known as the "Dignity Act." This legislation would fully prohibit correctional officers from shackling pregnant prisoners and ensure that no pregnant or postpartum prisoners are placed in solitary confinement. The bill was referred to the Senate Judiciary Committee (S.1524 2017). Its main sponsor, Senator Cory Booker of New Jersey, represents a state that has not banned shackling.

However, passage of this or other federal legislation banning the shackling of pregnant inmates is unlikely in the near future because this issue has not ascended to the top of the policy agenda of either party. Similarly, prosecutorial relief at the federal level is improbable, with Attorney General Jeff Sessions shifting the focus of the Justice Department to fulfill the goals of the Trump administration. With his "tough on crime" stance, Sessions is not likely to take up improving prison conditions as a priority. In fact, since being sworn into office, Attorney General Sessions has pushed to incarcerate more people for longer terms and encouraged federal prosecutors to seek the harshest sentences legally possible (Lee and Kaleem 2017). Many are hailing this change as a return to the War on Drugs, as federal cases are disproportionately drug-related; about half of those imprisoned on the federal level were charged with drug offenses (Lopez 2017). However, given the number of rules

governing this practice in federal prisons, blanket legislation at the federal level is most likely not necessary. Rather, emphasis on education and implementation is the next frontier.

State-by-state legislation and legal victories are significantly more likely in the near future, as the lobbying and organizing structures are leaner and more efficient at the state level. As a result, the patchwork system of individual state bans and federal case law will likely remain. Advocacy groups will play a key role in the movement to end perinatal shackling, by filing amicus briefs supporting plaintiffs in their cases against the criminal justice system and lobbying on the state level. However, as discussed, state shackling bans are not always effective due to a lack of implementation by individual prisons and correctional officers. To improve implementation, states can follow New York's lead and emphasize data collection and public reporting to ensure accountability.

While many small organizations work in their own fields to advocate against the shackling of pregnant inmates, large-scale change would require a wider interdisciplinary coalition of health-care and correctional professionals, as well as inmates, former inmates, and family members. Some of the most powerful advocates leading the movement against shackling come from the health-care field. Organizations such as the American Congress of Obstetricians and Gynecologists, the American Medical Association, and the American Public Health Association are joining civil-rights groups such as the Rebecca Project for Human Rights and the American Civil Liberties Union to advocate for ending perinatal shackling (American Medical Association 2015). The American Nurses Association specifically encourages advocacy in its Code of Ethics, stating that nurses are expected to protect and advocate for the rights, health, and safety of the patients they treat (Ferszt, Hickey, and Seleyman 2013). Correctional nurses are particularly suited for this role and can work to foster collaboration between medical staff, correctional staff, social workers, and prison wardens to identify problematic trends in the treatment of pregnant prisoners. They can also work to develop policies and practices that preserve the privacy of their patients while maintaining security during treatment and birthing and educating prison wardens and correctional staff (Ferszt, Hickey, and Seleyman 2013).

Ahrens (2015) writes that "while [the recent activist] focus on shackling has been useful and has prompted helpful policy changes, it has not—thus far—translated into a broader appreciation for the challenges and constraints encountered by incarcerated pregnant women and birthing mothers." A coalition including members of the health-care industry and human-rights organizations, along with legal scholars focused on reproductive rights, could start to address the underlying societal conditions that have allowed the practice to survive. This will be key if advocates hope to move beyond state-by-state legislative movement, and start to shift fundamental perceptions surrounding motherhood and criminality.

The past two decades have seen enormous change regarding the practice of shackling pregnant inmates. In a short time, a significant amount has been accomplished by state and federal courts, as well as state legislatures and corrections departments. Today, the practice of shackling all pregnant inmates is illegal or against official corrections department policy in roughly half of all state prisons—with six states having passed laws in the past four years alone. As such, this powerful trend shows no sign of abating, and may culminate in a society where women are no longer chained in their most vulnerable hour.

Appendix A: State Laws and Policies Against Shackling Pregnant Inmates, as of February 2018

	Law	Policy	Anti-Shackling Status	Year Law Passed, Updated	Number of Female Prisoners in 2015 †	Est. Number of Pregnant Prisoners in 2015 ††
Federal	No	Yes	Policy Only		12,953	777
State					98,542	5,913
Total					111,228	6,674
Arizona*	Yes	Yes	State Law	2014	3,981	239
California*	Yes	Yes	State Law	2012	5,785	347
Colorado*	Yes	Yes	State Law	2010, 2016	1,846	111
Delaware*	Yes	Yes	State Law	2012	537	32
Florida*	Yes	Yes	State Law	2012	6,943	417
Hawaii*	Yes	Yes	State Law	2011	702	42
Idaho*	Yes	Yes	State Law	2011, 2016	984	59
Illinois*	Yes	Yes	State Law	2000, 2012	2,675	161
Louisiana*	Yes	Yes	State Law	2012	2,046	123
Maine	Yes	No	State Law	2015	207	12
Maryland	Yes	Yes	State Law	2014	915	55
Massachusetts	Yes	Yes	State Law	2014	654	39
Minnesota	Yes	Yes	State Law	2014	771	46
Nevada*	Yes	Yes	State Law	2011	1,166	70
New Mexico*	Yes	Yes	State Law	2011	706	42
New York*	Yes	Yes	State Law	2009, 2015	2,354	141
Pennsylvania*	Yes	Yes	State Law	2010	2,819	169
Rhode Island*	Yes	Yes	State Law	2013	146	9
Texas*	Yes	No	State Law	2009	14,408	864
Vermont*	Yes	Yes	State Law	2005	150	9
Washington*	Yes	Yes	State Law	2010	1,455	87
Washington, DC	Yes		State Law	2015		
West Virginia*	Yes	Yes	State Law	2010	865	52
Alabama	No	Yes	Policy Only		2,590	155
Alaska	No	Yes	Policy Only		577	35
Arkansas	No	Yes	Court Ruling		1,402	84
Connecticut	No	Yes	Policy Only		1,121	67
Georgia	No	No	Not Banned		3,615	217
Indiana	No	No	Not Banned		2,540	152
Iowa	No	Yes	Court Ruling		808	48
Kansas	No	No	Policy Only		839	50
Kentucky	No	Yes	Policy Only		2,587	155
Michigan	No	Yes	Policy Only		2,273	136
Mississippi	No	Yes	Policy Only		1,316	79
Missouri	No	Yes	Policy Only		3,267	196
Montana	No	Yes	Policy Only		390	23
Nebraska	No	No	Court Ruling		429	26
New Hampshire	No	Yes	Policy Only		236	14
New Jersey	No	Yes	Policy Only, Law Proposed		908	54
North Carolina	No	Yes	Policy Only		2,689	161
North Dakota	No	Yes	Court Ruling		208	12
Ohio	No	Yes	Policy Only		4,430	266
Oklahoma	No	Yes	Policy Only		3,058	183
Oregon	No	Yes	Policy Only, Law Proposed		1,307	78
South Carolina	No	No	Not Banned		1,355	81
South Dakota	No	Yes	Court Ruling		416	25
Tennessee	No	Yes	Policy Only		2,640	158
Utah	No	No	Not Banned		515	31
Virginia	No	Yes	Policy Only		3,236	194
Wisconsin	No	Yes	Policy Only		1,408	84
Wyoming	No	Yes	Policy Only		267	16

Notes: State laws are legally binding and applicable to all correctional facilities in the state. Policies are official written recommendations by corrections agencies that, while also applicable to all correctional facilities in the state, may or may not have reporting requirements or consequences for nonadherence.

Sources:
† : Carson and Anderson 2016
†† : Thomas and Lanterman 2017
* : Fienauer et al. 2013
Maine : Sec. 1. 30-A MRSA c. 13, sub-c. 2-A
Maryland : HB0027 CH 0212
Massachusetts : General Laws Title XVIII, Chapter 127, Section 118
Minnesota : CHAPTER 234 - S.F. No. 2423
Washington, DC : Law 20-280

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