# Correctional Psychiatry

9

Sanaz Kumar and Philip J. Candilis

## Vignette

Mr. A, a 28-year-old single Black male, with a history of depression with psychotic features and posttraumatic stress disorder, was sentenced to 6 months in jail for a misdemeanor drug conviction. Upon admission, Mr. A was evaluated by a staff psychiatrist. Mr. A reported persistent low mood and irritability that was previously partially controlled with SSRI treatment and intermittent therapy. Mr. A did not endorse current symptoms of psychosis, suicidality, or homicidality. He reported that he recreationally uses fentanyl a few times per year and that his last use was 2 weeks ago, at the time of his arrest. The evaluating psychiatrist found that his drug screen was positive for opiates. Given persistent depressive symptoms, she increased Mr. A's SSRI dose and scheduled follow-up in 1 month.

Due to speculation that Mr. A is the target of a local gang, custodial staff housed him in a single-occupant cell in solitary confinement, also referred to as protective custody or segregation. One week later, Mr. A began to experience panic attacks several times per day. At night, these were accompanied by nightmares and waking up in a cold sweat. Mr. A asked the correctional officer on his block to move him back to the general population because he "can't take it anymore." Suspecting that Mr. A was overstating his symptoms, the correctional officer walked away with the time-honored phrase, "If you can't do the time, don't do the crime." Feeling helpless

S. Kumar (✉)
Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine and Health Sciences, Washington, DC, USA
e-mail: sanazk@gwu.edu

P. J. Candilis
Department of Psychiatry and Behavioral Sciences, George Washington University School of Medicine and Health Sciences, Washington, DC, USA

Saint Elizabeths Hospital, Washington, DC, USA
e-mail: philip.candilis@dc.gov



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and frustrated, Mr. A threw his food tray against the wall. Another officer approached the cell and encouraged Mr. A to talk to him. Mr. A shouted back, "You can't help me! Just leave me alone!"

During the next several days, Mr. A refused most of his food trays and communication with staff tapered off. Officers observed him quietly sitting on the end of his bed for hours at a time. One evening during unit rounds, an officer observed blood smeared on Mr. A's cell's floor. She asked Mr. A to tell her what happened, but he remained quiet. After calling for assistance, the officers opened the cell door and realized that Mr. A had been cutting his arm with a plastic fork. Staff immediately transported him to the infirmary for evaluation by medical and mental health providers.

## Mass Incarceration and Cultural Implications

### Introduction

In US correctional facilities, nondominant populations are disproportionately represented. These groups can include people of color, persons diagnosed with mental illness, and those from backgrounds of social and economic disadvantage [1]. Social inequities from the community are amplified in jails and prisons where resources are limited, autonomy is restricted, and security is the primary objective. These factors coalesce into a unique cultural context within correctional settings. Psychiatrists working there may consequently find themselves navigating an environment that runs counter to their usual clinical expectations.

### The Problem of Mass Incarceration

US incarceration rates are the highest in the world. Although the USA accounts for less than 5% of the world's population, it houses almost 25% of the world's prisoners [1]. According to the US Department of Justice's Bureau of Justice Statistics (BJS), about 2.2 million people were incarcerated in state prisons, federal prisons, and local jails on a given day in 2018 [2, 3]. To put this in perspective, this would be equivalent to incarcerating every resident of North Dakota, Alaska, and Wyoming [4].

Of these 2.2 million people, 1.47 million were confined in state and federal correctional facilities, where sentences are longer [2]. State and federal prisons incarcerate individuals who have been convicted of felony charges and are serving sentences of more than 1 year. Around the same time, 738,400 individuals were housed in county and city jails [3]. Jails house individuals who are awaiting trial or have already been convicted of misdemeanor charges. Because the incarceration data only represent snapshots in time, they grossly underestimate the total number of individuals incarcerated, particularly those in local jails where stays are briefer. During 2018, local jails admitted 10.7 million individuals total – nearly 15 times their average daily population [3].

These high incarceration rates raise the question of whether mass incarceration is an American cultural phenomenon. The US rate, at about 700 per 100,000 people, is seven times the average incarceration rate of Western European countries [1]. What accounts for this incongruence among democratic nations?

One hypothesis is that American values, which drive public policy decisions, contribute to this pronounced disparity. In their examination of German and Dutch prison practices, the Vera Institute of Justice, a US nonprofit research and policy organization, concluded that while German and Dutch criminal justice systems emphasize "resocialization and rehabilitation," the US system emphasizes "incapacitation and retribution" [5]. Because the German and Dutch systems focus on offenders' reintegration into society, they use prison sparingly and, instead, address crime through noncustodial sanctions and diversion [5]. Meanwhile, the US cultural emphasis on punishment and accountability favors a more extensive use of confinement [5].

Despite falling crime rates, US incarceration rates continue to rise: there has been a 500% increase in the number of incarcerated individuals in the last 40 years [6]. Experts attribute these changes to several factors. Crime rates may be falling because of demographic changes (e.g., an aging population), economic improvements (e.g., rising income and falling unemployment), and changes in policing tactics (e.g., the advent of community policing) [7]. It is not the case that crime rates are falling because more criminals are behind bars [8]. Rather, experts believe that social policy, such as regulations favoring lengthier sentences, stricter enforcement of laws, and changes in arresting patterns are driving the rise in incarceration [7]. These politically popular practices have led to the creation of what some experts have called a "carceral state" [9].

## Cost of Mass Incarceration

The human cost of mass incarceration cannot be overstated. The economic, social, and personal costs of this approach can be seen in government and household budgets, in community and family relationships, and in the actual conditions of confinement. Understanding how this system serves as a stressor on prisoners, families, and communities may assist correctional psychiatrists in appreciating the powerful context of their patients' experiences.

The USA spends more than $80 billion annually incarcerating people [7]. Housing inmates in state prisons costs anywhere from $14,780 to $69,355 annually per person [10]. Consider that in New York, where incarceration costs are high, the cost to house an inmate could cover an annual salary for a teacher or firefighter [11]. Communities pick up the tab for mass incarceration in other ways too. Individuals who are incarcerated are unable to provide financial support for their families, and when fathers are incarcerated, families are 40% more likely to live in poverty [7]. Costs accrue even after one's release from confinement: individuals with criminal histories have more trouble finding employment and earn 10–40% less than those without criminal histories [7]. Prisoners themselves are effectively removed from the work force and are unavailable to pay taxes in their communities.

Social costs of mass incarceration are found in communities across the country. Incarceration affects family relationships: most American prisoners are parents to minor children [12], and these children inevitably pay the price. The President's Executive Office report *Economic Perspectives on Incarceration and the Criminal Justice System* indicates that "Parental incarceration is a strong risk factor for a number of adverse outcomes, including antisocial and violent behavior, mental health problems, school dropout, and unemployment" [7]. Individuals who have been incarcerated are less likely to be engaged in civic and political matters [1]. This holds for their families as well.

Finally, mass incarceration imposes real health and human costs upon individuals within the walls of correctional facilities. As correctional institutions have swelled with inmates, overcrowding has led to unsafe practices in some jurisdictions. In 2011, the US Supreme Court ruled that California's prisons fell short in providing inmates' basic health needs: at a time when these prisons were operating at 200% capacity, overcrowding had strained the capacity of medical and mental health services [13]. Under those circumstances, an inmate died every 6–7 days because of inadequate medical care [13]. Suicidal inmates were confined to telephone-booth-sized cages without toilets, and wait times to see mental health providers were as long as 1 year [13]. As a remedy, the Supreme Court ordered California to immediately reduce the number of incarcerated individuals [13].

Psychiatrists may consequently come to believe that mass incarceration is a dysfunctional social approach that deserves closer scrutiny. Mass incarceration is costly for everyone. Indeed, because they are overrepresented in correctional settings, mentally ill individuals and people of color pay more than their share. Psychiatrists working in corrections must come to appreciate the entire range of cultural and institutional influences on those in US correctional systems and the irreparable costs of these systems.

## Overrepresentation of People of Color

People of color comprise a large segment of the incarcerated population. Black and Latinx persons make up more than half of those incarcerated in state and federal prisons, even though they represent less than one-third of the US population [7]. A report by the Sentencing Project, a US advocacy group, found that in state prisons people who are Black are incarcerated at 5.1 times the rate of people who are White [14]. The National Research Council report on the growth of incarceration concluded that Black people were incarcerated at six times the rate for White people, with Latinx people incarcerated at three times the rate for non-Latinx White people in 2010 [1]. These findings highlight a grim reality: nondominant cultural groups are more vulnerable to the idiosyncrasies of the judicial system.

Multiple factors, including arresting and sentencing practices, drive racial disparities in correctional settings. Implicit racial biases in law enforcement have been

identified in a number of federal oversight reports [15, 16]. These biases influence who police stop, search, arrest, and detain. The Bureau of Justice Statistics report on contacts between the police and public found that although Black, Latinx, and White drivers were stopped by police at similar rates, Black drivers were about three times as likely as White drivers and two times as likely as Latinx drivers to be searched during a traffic stop [17]. Although evidence indicates that people who are Black and people who are White use street drugs at similar rates [14], drug arrests since the 1970s have been higher for Black people [1]. Similarly, despite equivalent rates of cannabis use among Black and White people, Black individuals are 3.73 times more likely to be arrested for possession [18]. Even after arrest and conviction, harsher sentences for drug crimes disproportionately affect people who are Black [19]. Psychiatrists should be aware of these problematic influences that create racial disparities within the US criminal justice system.

Increasingly, courts are acknowledging that structural racism affects the legal system as it does every other facet of American society, contributing to inequality of opportunity and race disparities in mass incarceration. In June 2020, in the wake of George Floyd's death and subsequent mass protests, Washington Supreme Court Justices acknowledged the judicial system's role in "devaluing Black lives" and enabling "racist court decisions" [20]. In an open letter to the legal community, the Justices wrote, "The devaluation and degradation of Black lives is not a recent event. It is a persistent and systemic injustice that predates this nation's founding. But recent events have brought to the forefront of our collective consciousness a painful fact that is, for too many of our citizens, common knowledge: the injustices faced by Black Americans are not relics of the past. We continue to see racialized policing and the overrepresentation of Black Americans in every stage of our criminal and juvenile justice systems" [20].

Also in June 2020, Bernette Joshua Johnson, Chief Justice of the Louisiana Supreme Court, remarked on the injustices she observes in the criminal legal system. She reflected, "We need only look at the glaring disparities between the rate of arrests, severity of prosecutions and lengths of sentences for drug offenses in poor and African American communities in comparison to those in wealthier White communities, to see how we are part of the problem" [20]. Similarly, the California Supreme Court acknowledged "that the legacy of past injustices inflicted on African Americans persists powerfully and tragically to this day." This court added, "We must acknowledge that, in addition to overt bigotry, inattention and complacency have allowed tacit toleration of the intolerable. These are burdens particularly borne by African Americans as well as Indigenous Peoples singled out for disparate treatment in the United States Constitution when it was ratified [20]."

These sobering remarks echo sentiments sweeping across the nation as many Americans come to terms with an uncomfortable reality: despite progress following the 1960s civil rights movement, the legacy of slavery endures and racism against Black Americans persists – interpersonally, in institutions, and systemically. Psychiatrists working in correctional settings invariably hold these unpleasant truths in mind when assessing and treating patients.

## Overrepresentation of People with Mental Illness

Psychiatrists new to the field of correctional mental health may be surprised to learn how many inmates entering correctional facilities are afflicted with mental illness. Such individuals comprise another group that is disproportionately represented in correctional facilities.

For many experts, correctional facilities have become de facto psychiatric hospitals. According to the Treatment Advocacy Center, in 2012, about 356,268 prisoners with serious mental illness (SMI) – defined as illness that results in serious functional impairment – were incarcerated [21]. During that same time, less than 10% as many people with SMI, or approximately 35,000 individuals, were in state hospitals [21]. Three jails, the Los Angeles County Jail (CA), Rikers Island (NY), and the Cook County Jail (IL), are consequently the three largest inpatient psychiatric facilities in the country [22]. Although correctional facilities are not designed to care for individuals with SMI, the reality is that correctional facilities have become a common repository for them.

Some experts fault the deinstitutionalization of the state mental health systems for the relocation of individuals with SMI to correctional facilities [23]. When patients diagnosed with mental illness were released from psychiatric hospitals, many relocated to communities that lacked adequate mental health infrastructure. Limited psychiatric resources in the community – inpatient, outpatient, and residential treatment services – contributed to the large number of incarcerated individuals [24].

The Bureau of Justice Statistics (BJS) report *Mental Health Problems of Prison and Jail Inmates* underscores the pervasive nature of mental illness behind bars. This study found that 50% of inmates had a mental health problem as defined by current mental health symptoms or symptoms within the past 12 months [25]. By contrast, the National Institute of Mental Health reports that 18.9% of individuals in the USA suffered from any mental illness in 2017 [26]. Further review of BJS data revealed that 15% of state prisoners and 24% of jail inmates reported symptoms consistent with psychosis, 23% of state prisoners and 30% of jail inmates reported symptoms of major depression, and 43% of state prisoners and 54% of jail inmates reported symptoms consistent with mania [25]. Moreover, about three-fourths of individuals incarcerated in jails met criteria for substance use disorders [25]. Inmates with mental illness constitute a significant portion of correctional populations, and their presence clearly affects the culture of these institutions.

## Right to Treatment in Correctional Institutions

Prisoners are the only group in the USA with a constitutional right to medical treatment. Because of the inability of prisoners to obtain their own medical care in a total institution (an institution that controls all of their behavior), the Supreme Court in 1976 held that “deliberate indifference to serious medical needs of prisoners”

violated the Constitution's Eighth Amendment, the prohibition against cruel and unusual punishment [27]. Through this ruling, inmates who are post-conviction have a protected constitutional right to medical treatment, albeit at a standard below general malpractice (i.e., "deliberate indifference" falls below the negligence required of a malpractice case). The Constitution also guarantees pre-trial detainees medical treatment through the 14th Amendment's due process clause – the Constitutional passage that assures citizens in the individual states substantive and procedural rights. Prisoners' right to mental health treatment was supported in a subsequent federal ruling. In 1977, in the landmark case of *Bowring v. Godwin*, the federal court ruled that there was "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart" [28]. Together, these cases provide the foundation for incarcerated individuals' protected right to medical and mental health care.

Currently, the American Psychiatric Association (APA) expects that clinicians provide "the same quality of mental health services to each patient in the criminal justice system that *should be available* in the community [emphasis in original]" [29]. The APA intentionally sets a higher standard for prisoner mental health treatment than community mental health treatment because adequate services are not always available in open society [29]. This means that psychiatrists working in correctional settings are expected to provide optimal care despite sub-optimal settings and resource limitations [30]. When resource limitations interfere with appropriate service delivery, providers have, at a minimum, the responsibility to voice their concerns to administrative staff.

## Challenges of Practicing in Correctional Settings

Although there are many parallels between correctional and community psychiatry, the unique nature of correctional systems creates specific challenges. The culture clash of healthcare and security, the restriction of formularies and other resources, and the implicit social bias that creates this unique population all contribute to an environment that may be unfamiliar to many clinicians.

### Typical Responsibilities

Most psychiatrists working in correctional settings provide direct psychiatric care. In this context, common responsibilities include the routine diagnosis of mental illness, medication management, and performance of risk assessments.

Some facilities offer psychiatrists administrative positions or other leadership roles; for example, psychiatrists may serve as directors of mental health services for facilities or groups of facilities within a system. The APA encourages psychiatrists to undertake these positions because they provide opportunities to advocate for patients, improve the quality of mental health service delivery, and prepare patients for community transition [29]. In leadership roles, psychiatrists will have a voice at

the table with custodial leadership. In those cases, psychiatrists may communicate resource needs more effectively, improve psychiatric care within agencies, and facilitate productive relationships between providers and correctional staff. Providers and patients all benefit when psychiatrists assume leadership positions in correctional settings.

## Cultural Differences: Penal System Versus Mental Health System

The mental health paradigm is inherently at odds with the penal system. A 2015 Human Rights Watch report detailing the use of force on inmates with mental illness asserts that "The institutional culture within many corrections facilities is antithetical to—indeed hostile to—accommodating the needs of prisoners with mental disabilities" [31]. Whereas the US criminal justice system may be seen primarily as punitive rather than rehabilitative, psychiatrists are fundamentally healers who treat patients with compassion, regardless of their offenses. The disparate roles of correctional staff and clinical staff may consequently give rise to disparate professional cultures and attitudes.

In understanding the correctional paradigm, consider that correctional facilities exist first and foremost to house individuals who violate the law. Custodial staff is responsible for maintaining security and order, enforcing institutional regulations, and facilitating daily operations. Correctional officers are front line staff; they interact directly and consistently with inmates. Their jobs are challenging, particularly given common staffing shortages and problems with prison crowding. If correctional officers fail to detect security threats, the costs could be high – incarcerated individuals or other staff members could be seriously harmed. For this reason, correctional officers are trained to be vigilant in observing and attending to suspicious behavior. Keeping a security-first mindset helps them maintain safety as they perform professional duties.

Psychiatrists, as medical professionals, are trained to treat illness and alleviate suffering. Although psychiatrists, like correctional officers, also observe behavior closely, they are not usually looking for evidence of rule-breaking. Typically, psychiatrists seek behavioral clues that reflect their patients' emotional distress, irrational thinking, or cognitive impairment. Psychiatrists and correctional officers therefore observe individuals for different reasons, and their observations may lead them to different conclusions.

Such differences in institutional culture may pave the way for misunderstandings, frustrations, and tensions between custodial staff and mental health providers. Correctional officers, for example, may think that clinicians are coddling prisoners when they carefully draw out mental health symptoms and develop multifaceted treatment plans. Psychiatrists' emphasis on treatment to affect behavioral change may seem naive and misguided to custodial staff who suspect prisoners are manipulating the system. At the same time, psychiatrists may believe that correctional staff are impatient or unduly suspicious. These differences in perspective can lead to miscommunications that themselves undermine security and healthcare.

When possible, mental health providers can partner with custodial staff to promote mutual interests. The psychiatrist's job to communicate with patients, collect collateral information, and make psychiatrically sound judgments can successfully intersect the mission of custodial staff. Listening to reports from correctional officers, who spend considerable time with inmates, may be helpful in clarifying diagnoses or assessing treatment interventions. In weighing this data, clinicians may appropriately err on the side of patient health and safety. When mental health needs are effectively addressed, individuals are more likely to demonstrate adaptive, prosocial behavior. This is in the interest of all parties involved.

## Ethical Considerations of Professional Practice

Given the security-first mindset that predominates prison culture, custodial staff may occasionally pressure clinicians to depart from their traditional role as medical providers. Physicians may find that requests to breach confidentiality, search patients, or clear inmates for segregation compromise professional medical ethics. Although uncommon, facilities may even ask physicians to collect urine for security evaluations or force-feed patients [32]. Participating in tasks like these that are designed to advance penological interests corrupts the role of treaters, who are primarily responsible for promoting physical and mental health. National and international organizations recognize that although psychiatrists work within correctional settings, their role is not to enforce or advance institutional interests. The APA cautions, "Treating psychiatrists must not participate in making decisions about discipline, because this crosses ethical boundaries" [29]. At the same time, some respected commentators believe that psychiatrists can at least contribute to discussions of whether inmates understand the disciplinary proceedings themselves or whether their mental illness is a mitigating factor [33]. Nonetheless, the 2015 *United Nations Standard Minimum Rules for the Treatment of Prisoners* states, "Healthcare personnel shall not have any role in the imposition of disciplinary sanctions or other restrictive measures" [34]. Professional medical ethics governing physician behavior in the community also apply behind bars.

There are other instances where psychiatrists in correctional organizations may be asked to practice outside a direct clinical role. For example, psychiatrists may be called upon to perform court-ordered forensic assessments (e.g., competency to stand trial, criminal responsibility). The APA recommends that psychiatrists avoid performing these types of evaluations on patients they treat or have treated because of the inevitable conflicts between the obligations to the patient and the court [29]. This is the problem of dual, or multiple agency, in which professionals are torn by various allegiances: the patient, the employer, public safety, and the profession itself. Moral philosophers and forensic psychiatrists alike wonder whether any individual can withstand the balancing of their rights against the daunting counterweight of institutional obligations [35].

Professional organizations, including the APA and the National Commission on Correctional Health Care (NCCHC), offer guidance to providers who practice in

correctional institutions. NCCHC, for example, prioritizes the health and wellness of individual patients, leaving solitary confinement to the administrative process [36]. Reviewing such standards may help psychiatrists clarify their professional obligations and effectively respond to ethical dilemmas.

## Boundary Challenges

In correctional settings, prisoners, custodial staff, and clinical providers are all vulnerable to adopting an "us vs. them" mentality. When psychiatrists take sides, their neutrality is compromised, and they risk falling short in delivering the standard of care. Custodial and clinical staff can express strong emotional reactions or personal judgments about prisoners who have committed violent crimes, particularly those who have committed sex crimes or harmed children. Participating in derogatory conversations, however, biases providers against their patients and clouds clinical judgment. Further, therapeutic alliances can be jeopardized if prisoners detect providers' and officers' negative feelings.

Conversely, there are risks when psychiatrists overidentify with patients. Some clinicians view prisoners as victims of an unjust judicial system and may wish to rescue them from unfortunate circumstances [37]. Individuals who are incarcerated in turn may perceive these qualities in their providers and exploit them for personal gain. These prisoners may make inappropriate requests (e.g., permission for personal calls, assistance with legal defense, requests for outside items) that providers or other custodial staff members feel compelled to honor. In one famous case, a prison tailor in New York brought tools to two inmates, who then used them to escape. The tailor poignantly described how she became involved in the prisoner's scheme stating, "I believe I helped … [them] escape because I was caught up in the fantasy. I enjoyed the attention, the feeling both of them gave me, and the thought of a different life" [38]. Psychiatrists should be cautious if they feel inclined to depart from traditional clinical responsibilities. In these cases, immediate self-reflection and consultation with colleagues is critical in clarifying appropriate boundaries. Otherwise, repercussions for staff and patients can be serious.

## Resource Limitations

Mental health resources, including providers and psychotropic medications, may be more limited in correctional facilities than in community settings. Some jails and prisons do not meet professional mental health staffing recommendations [24]. For example, in 2016, The Boston Globe reported that 7 of 15 prisons in Massachusetts were classified as federally designated health professional shortage areas in mental health. These facilities employed less than 1 psychiatrist per 2000 inmates [39]. A 2018 study from the University of Michigan School of Public Health surveyed 20 correctional facilities from 6 states and found that 80% of the reporting facilities lacked adequate behavioral health staff to meet inmate needs [40]. Eighty-five

percent of facilities reported difficulty filling open behavioral health positions, and 70% reported difficulty retaining competent behavioral health staff [40].

For staffing in prisons, the APA recommends one full-time equivalent psychiatrist for every 150–200 patients with serious mental illness (SMI) on psychotropic medications [29]. In jails, where the turnaround is shorter and the acuity greater, the recommendation is 1 full-time psychiatrist for every 75–100 patients [29]. When facilities are clinically understaffed, psychiatrists experience pressure to accept large caseloads and compress treatment sessions. But resource limitations do not justify inadequate mental health treatment. Consequently, clinicians have a responsibility to communicate staffing needs to supervisors, facility administrators, and even legislators.

In addition to feeling the crunch of clinical understaffing, providers may feel constrained by prison pharmaceutical formularies. In correctional facilities, cost may limit the availability of psychotropic medication. Pharmaceuticals are expensive; in some states, they average 14% of prison healthcare spending [41]. A large portion of pharmaceutical spending may fund antipsychotic medications: in 2012, California spent 20% of its $144.5 million pharmaceutical budget on antipsychotic medications [42]. To cut these costs, correctional facilities may strictly limit medication choices. In some facilities, they do so by limiting the psychiatric formulary to a few first-generation antipsychotic medications and other older agents [43]. This practice, which dramatically restricts treatment options, may be why some experts have concluded that psychiatric treatments in correctional standards deviate from the accepted standard of care [30]. Because requesting non-formulary medications is a tedious process by design, providers may be reluctant to make such requests. Advocating to administrators about appropriate medication access, like concerns about understaffing, remains important.

## Security Restrictions

Correctional treatment settings differ from community treatment settings in their security protocols, which can interfere with the reliable delivery of mental health services. Escorting patients to providers' offices can be time and labor intensive, particularly when prisoners are in restrictive housing units and require handcuffs and shackles prior to transport. Facilities may limit the number of individuals in a patient waiting area, and waiting for patients may interrupt clinical workflow. Further, providers may be unable to make scheduled appointments for stretches of time secondary to movement restrictions, especially unit head counts. Given the importance of institutional security, providers have limited work-arounds to improve service delivery and consistency.

Security limitations extend to practitioner relationships with the prisoners themselves. There are occasions when providers may learn about potentially dangerous behavior (e.g., plans to riot, escape, assault others) and must legitimately report to the authorities. This is best done in the context of clear communication with patients about the limits of confidentiality and a robust informed consent process prior to starting treatment.

Concerns about security and drug diversion may also drive clinicians' prescribing practices. In correctional facilities, medications are a form of currency. Medications can be sold for money, bartered for items of interest, or traded for sexual favors. Given elevated rates of substance misuse among inmates, medications with mind-altering properties like benzodiazepines, stimulants, opiates, and even antipsychotics have great diversion potential. As a result, some clinicians may be reluctant to prescribe these medications even when they are clinically indicated.

## Threats to Confidentiality

Psychiatrists appreciate that patient expectations of confidentiality are essential to the development of strong therapeutic alliances. Because security constraints in correctional settings can compromise privacy (i.e., officers within earshot of doctor-patient conversations), psychiatrists may find themselves making extra efforts to maintain confidential communication with patients. They may avoid "cell-side" or "cell-door" encounters, insisting that patients be evaluated in private examination rooms whenever possible. When examination room doors must be open for security purposes, providers may speak softly to limit others overhearing confidential communications. As in the community, confidentiality limits do include obligations to report suicidality and homicidality. However, psychiatrists working in correctional settings may indeed break confidentiality in cases of security threats like plans to riot or escape.

## Mental Health Stigma

Social stigma associated with mental health treatment may be more prevalent in correctional settings than in all of community mental health. As the Boston Globe's Spotlight team describes, "The prison environment itself is a major obstacle to treatment: In a culture ruled by aggression and fear, the trust and openness required for therapy are exponentially harder to achieve" [39]. Prisoners with mental illness may therefore be less likely to seek treatment because other prisoners may view them as weak or vulnerable. They may be intimidated, robbed, or sexually assaulted because of their status. Liberal psychiatric screening practices, specialized mental health units, mental health rounds, and public education about mental illness are all strategies that may facilitate access to treatment for those who are reluctant to seek it themselves.

## Implicit Racial Bias

Psychiatrists working in correctional settings must also be mindful of how implicit racial biases within the profession may affect provision of mental health services. In 2020, American Psychiatric Association (APA) President Jeffrey Geller

acknowledged the impact of these biases within psychiatry's largest and most prominent organization, the APA [44]. Dr. Geller asserted, "The history of the APA, going back to its very roots in the 1700s, is scarred with structural racism and racist ideas. While efforts have occurred over the years to rectify this problem, particularly by Black psychiatrists, as a field and organization we still have a very long way to go" [44]. To bring awareness to systemic racism within the profession, Dr. Geller formed the APA Presidential Task Force to Address Structural Racism Throughout Psychiatry. This task force was charged with the mission to study the profession's history of structural racism, communicate its impact on mental health, and develop actionable recommendations for change [44].

Implicit clinician bias is not benign and can have serious consequences for patients of color. Studies have found that Black patients are more likely to be diagnosed with schizophrenia than affective disorders when compared to White patients [45]. One recent study of more than 1600 patients in an outpatient mental health center found that clinicians underemphasize the relevance of mood symptoms among Black individuals compared with other racial-ethnic groups [46]. These findings are concerning given that schizophrenia carries a poorer prognosis than affective disorders. Further, treatment of psychotic illnesses may not address affective symptoms, and antipsychotic medications are associated with potentially irreversible metabolic and movement side effects.

Psychiatrists may take some well-established steps to reduce the effects of implicit bias. They should practice self-awareness and challenge internalized assumptions about people of color. Slowing down during clinical evaluations and consciously taking the time to assess each patient as an individual – rather than a member of a stereotyped group – are essential. Maintaining a reflective mindset, as opposed to a reactive one, should be the goal. In addition, psychiatrists may take implicit association tests, attend race equity trainings, and consult frequently with colleagues.

## Special Considerations When Working with Patients in Correctional Settings

Individuals with mental illness, a population that is disproportionately represented in correctional institutions, face unique challenges in confinement. Compared to individuals without mental illness, individuals with mental illness are more likely to commit suicide, experience victimization, and be confined to solitary. Consequently, psychiatrists often find that trauma-informed approaches and emphasis on individual safety are essential when working with these patients.

### Suicide Risk

As a population, incarcerated individuals are at increased risk for suicide. In jails, suicide has been the leading cause of death since 2006: suicide accounted for

roughly one-third of all jail deaths in 2016 [47]. In prisons, suicide accounted for 6.8% of all deaths in 2016 [48]. By contrast, national suicide rates in the population at large are considerably less; in 2016, suicide accounted for 1.6% of all deaths [49]. Correctional organizations are increasingly recognizing that suicide in prisons and jails is a public health crisis and that suicide prevention programs are integral components of their mental health delivery systems.

Individuals who are incarcerated encounter many stressors that contribute to suicidality. They may be particularly vulnerable to feelings of hopelessness, helplessness, and anxiety as their cases make their way through court. The APA cautions that individuals who are incarcerated are at higher risk for suicidality at certain times: upon admission, when facing new legal problems, after receiving bad news, following trauma, after experiencing rejection, as mental illness is exacerbated, and when housed in administrative segregation [29]. Given the dynamic and unpredictable experience of incarceration, mental health clinicians should screen for suicidality and associated risk factors at every clinical encounter. Researchers have identified associated risk factors including mental illness, substance use disorders, psychosocial stressors associated with incarceration, problems with support networks, and conditions of confinement [50].

## Trauma and Victimization

Not only are individuals with mental illness more likely to harm themselves when incarcerated, but they also are more likely to be harmed. According to BJS data, prisoners with mental health problems are already more than twice as likely to report a history of past physical or sexual abuse [25]. About 6.3% of individuals identified with serious psychological distress in prisons reported sexual abuse by another inmate; by contrast, this rate is only 0.7% among those without mental illness [51]. The well-known National Prison Rape Elimination Commission Report confirmed that mental illness increased inmates' risk for sexual abuse by other prisoners [52]. Authors of a 6-month survey that examined 13 prisons in a mid-Atlantic state prison system concluded that 1 in 12 male prisoners with mental illness reported sexual victimization, compared to 1 in 33 male prisoners without mental illness [53]. Given these findings, screening for trauma and victimization is a necessary component of mental health evaluations and, like suicide screening, should occur at every clinical encounter.

In recent years, there has been compelling data suggesting that LGBTQIA prisoners are particularly vulnerable to sexual victimization. BJS data found that 39.9% of transgender adult individuals in prisons and 26.8% in jails reported sexual victimization between 2011 and 2012 [51]. By contrast, 4.0% of cisgender individuals in prisons and 3.2% of those in jails reported sexual victimization [51]. Further, among prisoners who identified as nonheterosexual, 12.2% reported sexual victimization by another inmate compared to 1.2% of those who identified as heterosexual [51].

### Behavioral Challenges

Incarcerated individuals with mental illness are more likely to be charged with violating prison rules than their nonmentally ill counterparts [25]. They are more likely to engage in certain disruptive behaviors like property destruction, fire setting, and fecal smearing [54]. They are also more likely to be charged with physical or verbal assault on staff members or other inmates [25]. A report by Human Rights Watch (HRW) explains, "Prison is challenging for everyone, but prisoners with mental disabilities may struggle more than others to adjust to the extraordinary stresses of incarceration, to follow the rules governing every aspect of life, and to respond promptly to staff orders" [31]. The implications of this disruptive behavior are profound: they may result in disciplinary solitary confinement or use of force. Advocacy for more mental health resources may counter one particular HRW report that concluded that misuse of force against prisoners with mental health problems is widespread [31].

## Solitary Confinement

### Background

Solitary confinement, or segregation, is a prison within a prison: individuals' autonomy, physical movement, and opportunities for social contact are even more restricted than in the general population. Social inequities are also more pronounced. BJS data demonstrate that individuals who are younger, without high school diplomas, and members of the LGBTQIA community are more likely to spend time in solitary confinement than their counterparts [55]. Individuals with mental illness are also disproportionately affected by segregation practices [55].

In correctional settings, segregation technically refers to the practice of removing individuals from the general population and confining them to dedicated cells for 22–24 hours a day. Placement may occur for a variety of reasons, including disciplinary and protective purposes. Administrators may wish to discipline prisoners from the general population or protect members of a minority gang or incarcerated former police officers. Individuals in segregation reside in special housing units (SHUs or "shoes") within correctional facilities. The most violent and disruptive offenders may be confined to supermaximum security prisons (supermax), highly secure institutions in which prisoners are "single-celled" for an indefinite period of time with minimal human contact [56]. Other names for segregation include restrictive, segregated, or secure housing; colloquially, segregation may be called "the box" or "the hole."

Segregation may be classified by its intended purpose: protective custody, administrative segregation, and disciplinary segregation. Protective custody is intended to protect individuals who are vulnerable to abuse or harm and often include transgender persons or prisoners who have committed sexual offenses. Administrative

segregation is designed to isolate individuals who pose a risk to others or the security of the facility (e.g., gang members). Finally, disciplinary segregation punishes prisoners who violate institution rules by possessing contraband or assaulting correctional officers.

In the Federal Bureau of Prisons, a segregated housing unit cell is typically 60 to 80 square feet and contains a bed platform, toilet, sink, and a narrow window [57]. In other facilities, cells may be as small as 50 square feet, smaller than a standard parking space [58]. Some SHU cells lack windows and are illuminated with artificial light all day and night [54]. In those settings, environmental stimuli are abnormal [59]. Furnishings tend to be sparse, and personal items, such as reading materials and toiletries, are restricted and subject to search.

Even more crucially, meaningful human contact and social activities are limited. In some jurisdictions, inmates are only permitted one phone call or social visit per month [60]. Contact visits and congregate activity (e.g., dining, religious services) are typically prohibited [54]. In fact, in some cases, visits may only occur by closed-circuit television [54]. Direct contact with security staff is minimal and may consist only of the brief conversation when food trays are delivered through slots in the cell door. Contact with other inmates is also restricted but might occur during the 1 hour recreational break each day. Prisoners may develop creative ways to communicate between cells. Using the doors or vents, prisoners may "fly a kite," surreptitiously casting handwritten notes along a string across the cell block. Because opportunities to participate in educational, vocational, and therapeutic programming are uncommon, inmate activity in segregation is uniquely limited.

## By the Numbers

Precise numbers of individuals in restrictive housing are hard to come by due to differences in definitions and lack of systematic tracking [57, 61]. Based on data collected from 43 prison systems, the Association of State Correctional Administrators (ASCA)-Liman 2018 nationwide survey on restrictive housing estimated that approximately 61,000 prisoners were in restrictive housing across the USA in the fall of 2017 [62]. These numbers do not account for individuals in jails, juvenile facilities, military, and immigration detention centers. This study also found that among survey respondents, on average 4.6% of prisoners were in restrictive housing. Further, Black prisoners comprised a greater percentage of the population in segregation than they did in the total custodial population [62].

The Government Accountability Office calculated that the Bureau of Prisons confines about 7% of inmates in segregated housing units [63]. BJS data estimates that on an average day in 2011–2012, up to 4.4% of state and federal inmates and 2.7% of jail inmates were held in restrictive housing [55]. This report also concluded that nearly 20% of prison inmates and 18% of jail inmates spent time in restrictive housing in the previous 12 months or since incarceration at their current facility.

The 2018 ASCA-Liman survey also collected data on lengths of stay in segregation: 54.4% were in segregation under 3 months, 26.9% from 3 months to 1 year, and 19.1% for more than 1 year [62]. The Federal Bureau of Prisons, which houses 129,430 inmates in custody, reported that 8.3% of all prisoners were in restricted housing as of July 2020 [64]. Around 30% of this group, or 3413 inmates, were in restricted housing for more than 90 days [64].

Perhaps because of the stresses on inmates and institutions, there has been a trend in recent years to decrease the number of segregated inmates. In 2016, the Federal Bureau of Prisons reported a 25% reduction of restricted housing population since 2012 [57].

## Mental Illness and Segregation

It is not uncommon for individuals with mental illness to be confined in segregation. BJS data demonstrate that solitary confinement is closely associated with mental health problems: among those experiencing psychological distress, 29% of individuals in prisons and 22% of those in jails were housed in segregation at some point during the previous 12 months [55]. Further, about a quarter – 26% of prison inmates and 23% of individuals in jails – who had been told they had mental illness also reported a history of time in restrictive housing. By contrast, around 15% of individuals incarcerated in prisons and jails with no symptoms of mental health problems were in restrictive housing units during the same period [55].

These findings have been replicated in other studies. In one study, Cloyes et al. (2006) assessed 87 male supermax security unit prisoners and found that 29% of them showed evidence of mental illness [65]. A significant number met the study's criteria for "serious psychosocial impairment." A Danish study that compared 133 inmates in solitary confinement to 95 non-solitary inmates found that the incidence of psychiatric illness was 28% in those who were segregated as opposed to 15% in those who were not [66].

Individuals with serious mental illness may struggle to follow institutional rules and may be confined to segregation as punishment [67, 68]. As previously described, they may have difficulty managing their emotions, leading to altercations with custodial staff and disruptive behaviors [67, 68]. Providers who work in correctional medicine appreciate how mental health symptoms can prolong segregation stays; in its position statement on solitary confinement, the National Commission on Correctional Health Care (NCCHC) asserts, "Continued misconduct related to [prisoners'] underlying mental health issues, which is often exacerbated by their isolation, can result in their being held in solitary confinement indefinitely" [36].

In facilities where mental health resources are limited, disciplinary segregation may become the default placement for individuals with mental illness who are disruptive and inconvenient [67, 69]. This is part of the incentive for systems to develop specialized mental health units or residential treatment programs which specialize in the treatment and support of mentally ill prisoners who have problems functioning in the general population.

## Psychological Impact of Segregation

Conditions of segregated housing may exacerbate mental illness or contribute to the development of new psychopathology. A growing body of literature details potential adverse psychological effects associated with solitary confinement [67, 70]. Although some of these studies and reports have been criticized for their methodologic limitations [61, 71], this literature contributes to the increasing objections to segregation practices, particularly when applied to individuals with serious mental illness. At the same time, one well-known but counterintuitive study with stronger methodology did not substantiate the connection between psychological decline and administrative segregation [72].

Several experts have posited a psychiatric profile for prisoners in solitary confinement. In *A Sourcebook on Solitary Confinement*, criminologist Sharon Shalev hypothesizes that "three main factors are inherent in solitary confinement – social isolation, reduced environmental stimulation, and loss of control over almost all aspects of daily life" [73]. These factors all contribute to the distress associated with segregation. Stuart Grassian, a psychiatrist who studied solitary confinement early on, hypothesizes that limited environmental stimulation and social isolation, two hallmark features of solitary confinement, together exert a synergistic and toxic effect on mental health [74]. Based on his evaluation of hundreds of prisoners, Grassian posits that segregation is associated with a specific psychiatric syndrome – often referred to as "SHU syndrome" – characterized by hyper-responsivity to external stimuli, perceptual distortions, panic attacks, paranoia, poor impulse control, obsessional thinking, and other thinking problems. Craig Haney, a social psychology professor, reached similar conclusions during his study of 100 prisoners at California's notorious Pelican Bay State Prison, a supermax facility [67]. Haney found that almost all prisoners suffered from nervousness/anxiety, chronic lethargy, ruminations or intrusive thoughts, oversensitivity to external stimuli, irrational anger and irritability, confused thought processes, difficulties with attention/memory, and a tendency to withdraw socially. Among this group, 70% felt that they were on the verge of an emotional breakdown [67]. Haney theorized that prisoners with mental illness were particularly vulnerable and "at greater risk of having this suffering deepen into something more permanent and disabling" [67].

Other surveys and studies demonstrate the potential psychological impact of solitary confinement. One multi-site study found that among individuals who were recently released from incarceration, those from solitary confinement were more than two and a half times as likely as those who were not in segregation to report PTSD symptoms [75]. Another study in Denmark found that the incidence of adjustment disorders among prisoners in solitary confinement was double that of other prisoners [66]. In his work, psychiatrist Terry Kupers asserts that almost all individuals in supermax facilities report problems with anxiety, sleep, focus, and memory [68]. Findings like these have led the NCCHC to conclude that even individuals without a history of mental illness may experience a "deterioration of mental health" in solitary confinement [36].

These vulnerabilities can turn out to be life-threatening. Suicide and self-injury occur disproportionately in segregated housing units. In a large study of the New York jail system, Kaba and colleagues found that self-harm was associated significantly with being in solitary confinement at least once [76]. This seminal study examined more than 240,000 incarcerations and 2000 acts of self-harm. The authors calculated that although "7.3% of admissions included solitary confinement, 53.3% of acts of self-harm and 45.9% of acts of potentially fatal self-harm occurred within this group" [76].

Supporting data from a Texas study similarly suggests that individuals in solitary confinement are five times more likely to commit suicide than those in the general population [77]. Further, in 2013, experts concluded that prisoners housed in California's segregation units were 33 times more likely to kill themselves [78]. Raymond Patterson, who served as a psychiatric expert for this case, calculated that 47% of the 15 completed suicides that occurred in the first 6 months of 2012 took place in secured housing units [79].

Youth who are confined and isolated are even more vulnerable. The US Attorney General's Task Force on Children Exposed to Violence concluded that "Confined youth who spend extended periods isolated are among the most likely to attempt or actually commit suicide" [80]. One study, which examined juvenile suicides in confinement (e.g., juvenile detention centers, reception centers, training schools, ranches, camps, and farms), concluded that half the victims were on room confinement at the time of the death [81].

The psychological impact of segregation may persist after release from incarceration. One study that followed 230,000 individuals released from incarceration in North Carolina revealed devastating effects associated with a history of solitary confinement [82]. The authors found that when comparing individuals who spent any time in restrictive housing with those who had not, individuals in the former group were 24% more likely to die in the first year after release, especially from suicide (78% more likely) and homicide (54% more likely) [82]. This solitary confinement group was also 127% more likely to die of an opioid overdose within the first 2 weeks after release [82].

## Mental Health Screening and Monitoring in Segregation

Given the prevalence of mental illness, self-harm, and suicide in solitary confinement, correctional systems are developing protocols that provide improved access to mental health services. To facilitate greater access, the APA recommends that institutions conduct mental health screening prior to placing individuals in segregation; this evaluation may include a suicide risk assessment and an assessment of whether an individual's psychiatric illness could worsen in segregation [29]. There is, however, controversy about how involved physicians should be in this process. The NCCHC asserts, "Health staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation" [36]. Similarly, the World Health Organization (WHO) states that "doctors should

not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment" [83]. It is not yet clear how professional roles can avoid the conflict between facilitating the use of segregation and protecting inmates from its effects.

After individuals are moved to solitary confinement, frequent mental health rounds may promote early detection of psychiatric decompensation or the emergence of symptomatology. Individuals at risk, or with early symptoms, may then be referred to psychiatrists for more comprehensive assessments and treatment planning. Inmates without histories of mental illness are also vulnerable to psychological distress. Regular screening in restrictive housing units can be useful for anyone entering that highly controlled environment.

## Barriers to Treatment in Restricted Housing Units

Individuals in solitary confinement confront many other kinds of barriers that impede the efficient delivery of mental health services. From a staffing standpoint, transporting inmates from segregation is time and labor intensive. Before inmates can meet with clinical providers, they are often searched and shackled. Escorts are first required to transport individuals to infirmaries and then to supervise them as they await their appointments.

Physical barriers may also impair the quality of a therapeutic relationship between healthcare providers and prisoners in solitary confinement. In some facilities, providers evaluate patients through a glass partition or while inmates are confined to a metal cage. In other facilities, evaluations are conducted "cell-side" via slots on the door or by telephone or speakers. Consequently, prisoners are reluctant to speak openly about mental health symptoms due to their all too reasonable concerns that officers and others may overhear information that can make them a target.

Security regulations and resource limitations also restrict access to therapeutic activities like individual therapy, group therapy, and life skills development [59, 69]. In segregated housing units, it is not uncommon for mental health treatment to consist primarily of psychotropic medication management without therapy [69]. In some facilities, clinicians deliver therapeutic services despite security restrictions. For example, groups may be conducted while individuals are separated in "therapeutic modules" [57], which resemble large phone booths [84]. These are rolled into position and arranged in a semicircle or classroom lineup that does little to facilitate group interaction.

Skepticism of prisoner requests for mental health services may prevent or delay access to treatment. Kristin Cloyes, a researcher who studies correctional health programs, puts it this way, "Doubts about the authenticity of symptoms and concerns of manipulation and malingering are a central focus for SMU [special management units] staff, who may interpret decompensation as a strategic manipulation for softer conditions" [65]. In a culture where corrections officers are the

gatekeepers of clinical access, privileges, and contact with the outside world, this can be a significant hurdle for prisoners to overcome.

## Movement Away from Segregation

Given the psychological impact of segregation, national and international organizations have been increasingly critical of segregation practices; in some cases, they have called for an end to the practice.

In the USA, psychiatric and correctional health organizations have advocated for limited use of solitary confinement. In 2012, the APA contended that "Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential harm to such inmates" [85]. Similarly, in 2016, the NCCHC issued a position statement criticizing both prolonged use and application to vulnerable populations [36]. In unequivocal terms, the organization asserted, "Prolonged (greater than 15 consecutive days) solitary confinement is cruel, inhumane, and degrading treatment, and harmful to an individual's health." The NCCHC also recommended that mentally ill individuals, juveniles, and pregnant women "be excluded from solitary confinement of any duration" [36].

Perhaps reacting to such strong sentiments, the US government has steered away from segregation. From 2012 to 2016, the Federal Bureau of Prisons decreased the number of prisoners in restrictive housing by almost one quarter [57]. In 2016, President Obama vowed to adopt the US Department of Justice (DOJ) recommendations to further reduce the use of segregation [86]. He prohibited use of solitary confinement as punishment for prisoners who commit low-level infractions and banned its use for juvenile offenders in the federal prison system. Demonstrating an appreciation for the vulnerabilities of those with serious mental illness (SMI), the DOJ had already recommended that inmates with SMI not be segregated unless they posed an immediate and serious danger and no reasonable alternative existed [57]. Further, the DOJ asserted that suicidality and active psychosis are contraindications to segregation.

Internationally, proposals calling for the near elimination of solitary confinement are ubiquitous. In 2013, Physicians for Human Rights (PHR) recommended that solitary confinement be used "only in very exceptional cases, for as short a time as possible, and only as a last resort" [87]. Barring "exceptional circumstances," United Nations (UN) Special Rapporteur on Torture, Juan Méndez, called for countries to prohibit solitary confinement [88]. He asserted that in some cases solitary confinement may "amount to torture or cruel, inhuman or degrading treatment or punishment" [88]. In the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, the UN prohibits solitary confinement when prisoners have mental or physical disabilities that would worsen if placed in solitary [34]. Further, the organization continues to prohibit use of solitary confinement for women and children. This movement to reduce the use of solitary confinement appears to be gaining momentum.

## Vignette Discussion

Taking these themes into consideration, a discussion of Mr. A's case can raise some critical issues. Mr. A presents to the infirmary following self-injurious behavior. Staff may be skeptical of his behavior, but clinicians must not make assumptions and should consider a number of themes. Mr. A has experienced changes in mood and appetite, panic attacks, and nightmares, all of which may have been exacerbated by his stay in solitary. Psychiatric evaluation therefore begins with a thorough suicide risk assessment followed by assessment for symptoms of depression, anxiety, posttraumatic stress disorder, psychosis, and mania. Because the clinician knows that illicit substances are available in jail and that Mr. A has a history of opiate use, she will rule out any ingested substances that could contribute to his presentation. To obtain collateral information, she speaks with the correctional officers who report that Mr. A has appeared more quiet and socially withdrawn during the past few days. He has not been receiving communication through the informal "kite-flying" process on the block.

During the risk assessment, Mr. A reports to the psychiatrist that he does not care if he dies. He says, "What's the point of living? Whether I live a clean life or mess up it feels like the system is against me anyway." He tells the psychiatrist about the many times he has been stopped and searched as a pedestrian because he was "in a high crime area" or because the police thought he "did not belong" in the neighborhood. Acknowledging that Black men are disproportionately targeted by law enforcement, the psychiatrist validates Mr. A's experiences. Using a trauma-informed approach, the psychiatrist listens empathically, while Mr. A describes the frequent violence he witnesses in his neighborhood, his struggles to make ends meet, and his guilt about letting down his kids. He describes vivid nightmares and flashbacks during this incarceration along with feelings of numbness. Mr. A also reports frustration that he was placed in protective custody when he doesn't feel targeted at all.

The psychiatrist and Mr. A collaboratively develop a comprehensive treatment plan. Both agree that his depression, anxiety, and PTSD have been exacerbated in jail. Mr. A agrees to suicide monitoring on the mental health unit. The psychiatrist optimizes Mr. A's antidepressant given his report that it helped in the past. She schedules him for weekly appointments with a cognitive behavioral therapist. Mr. A declines the psychiatrist's recommendation that he also join the men's trauma group but says he will alert the doctor if he changes his mind. Meanwhile, the psychiatrist asks that a housing supervisor meet again with Mr. A to determine whether general population is more appropriate than protective custody.

During the next 48 hours, while Mr. A remains on suicide monitoring, the psychiatrist sees him daily. Mr. A denies suicidal ideation during that period. He is released to the general population. During the next 2 months, Mr. A's visits with the psychiatrist are tapered from weekly to monthly. Meanwhile, he continues to meet with his therapist weekly and improves his understanding of the connection between his thoughts and feelings. Mr. A increases contact with his family via phone and letters and reports that he feels less isolated. During the subsequent 2 months, Mr. A reports improved mood, less anxiety, and fewer panic attacks. As his sentence

comes to an end, he and the unit social worker begin discharge planning, including transition to community mental health services.

## Conclusion

When setting foot inside prisons and jails, psychiatrists may feel like they have entered uncharted territory. They may be surprised by the amplification of the community's inequities, especially the overrepresentation of individuals with mental illness and nondominant populations. They may be uncomfortable with the seemingly harsh "security-first" mindset of custodial staff. They may be frustrated by resource limitations like staff shortages and restrictive formularies. Moreover, psychiatrists may be uncomfortable with the realization that many of their patients are in segregated housing, a setting where human contact is limited, mental health symptoms may be exacerbated, and facilitating access to treatment is cumbersome.

Cultural competence in correctional psychiatry requires an understanding of all the social forces driving social and racial disparities in the judicial system. Alongside this is the recognition of the distinct roles of officers and clinicians and the appreciation for how resource limitations and security profoundly shape day-to-day experiences for both inmates and providers. Segregation in particular is the setting where all these influences converge to create a unique vulnerability for prisoners.

Despite the many challenges of working in correctional psychiatry (summarized in Table 9.1), providers may rest assured that the psychiatric standard of

**Table 9.1** Challenges and interventions of practicing psychiatry in correctional facilities

| Challenges of practicing psychiatry in correctional facilities | Interventions |
|---|---|
| Risk of boundary crossings | Practice self-reflection<br>Avoid rescue fantasies and overidentification with patients<br>Seek supervision from colleagues |
| Resource limitations (e.g., staffing, restricted formularies) | Apply for positions that provide direct access to custodial leadership, these offer opportunities to advocate for patients' needs |
| Threats to confidentiality | Inform and remind patients of these risks at each encounter<br>Avoid "cell-side" assessments<br>Use private examination rooms<br>Speak softly, and be mindful of surroundings |
| Mental health stigma | Implement liberal screening practices<br>Offer public education to improve awareness about mental illness (e.g., informational trainings, groups, posters) |
| Implicit racial bias | Practice self-awareness and challenge internalized assumptions<br>Slow down when assessing patients from nondominant cultures to avoid risk of reflexive judgments<br>Make an effort to see each patient as an individual, rather than a member of a stereotyped group<br>Take implicit association tests, attend bias, culture, and race equity trainings |

care does not change when they enter correctional facilities. Practicing in accordance with professional ethics is an expectation, not a choice. Comprehensive diagnostic evaluations and targeted treatment plans serve patients well. And when providers observe system weaknesses, dangerous practices, or inadequate services, they can practice a well-informed advocacy that supports patients and systems alike.

## Summary of High-Yield Points

- Despite falling crime rates, US incarceration rates continue to rise and are among the highest in the world.
- Mass incarceration disproportionately affects people of color and people with mental illness. Its effects cannot be overstated and include significant economic, social, health, and human costs on individual, family, community, and national scales.
- Prisoners have a right to medical treatment including psychiatric care. However, there are challenges to delivery and implementation of treatment, including resource limitations, mental health stigma, and security restrictions.
- Psychiatrists working in jails and prisons are confronted with the challenges of a penal system where punishment and security, rather than treatment and rehabilitation, are primary objectives.
- Segregation, or solitary confinement, may exacerbate mental illness or contribute to the development of new psychopathology. National and international organizations have been increasingly critical of segregation practices; in some cases, they have called for an end to the practice.
- Individuals in correctional organizations, particularly those with mental illness, are at increased risk of victimization including physical and sexual assault, as well as self-harm and suicide.

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