Mass Incarceration and Mental Illness: Rethinking the Front Lines of U.S. Mental Health Care

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Disclosures

- I do not have commercial relationships related to this material to disclose

- The views expressed in this presentation are mine and do not necessarily reflect those of my employers

Finding a Voice

Elizabeth Ford, M.D.

Long before COVID-19's death march and the continued killing and imprisonment of Black people by the criminal legal system emphasized the profound and unjust racial and health inequities that exist in the United States, I was entrenched in my own ethical turmoil.

After I had spent 20 years learning to be a psychiatrist for people in New York City with serious mental illness who were detained in the city's jails, including on Rikers Island, my physical and emotional health was suffering. I knew that I needed to leave the hospital and jail institutions with which I had become so familiar, but I was afraid. Afraid to leave the traumatized professional family with whom I had formed such close bonds. Afraid to step into a new role where I would be tested and judged. Afraid that the dehumanizing and cruel behaviors I witnessed were not limited just to captivity. I had heard too many patients in jail talk about "outside," where the risk of being raped in a shelter on a Code Blue winter night or being kicked out of an emergency room by angry doctors was worse than incarceration.

My journey began while I was working in, and eventually leading, one of the most historically notorious psychiatric units in the country: the Bellevue Hospital Psychiatric Prison Ward. It is there where patients from the jails go when they are too dangerous for jail. Decisions about access to these coveted inpatient beds are based on the laws of New York State (1, 2) that empower doctors to subjectively diagnose mental illness on the basis of a manual (3) whose field trials do not include the Black and Brown, impoverished, incarcerated patients I was trying to treat. Highly stigmatized diagnostic labels such as "malingerer" and "personality disorder" were too quickly applied to traumatized patients by psychiatrists and psychologists who had little idea of the true impact of confinement. My work there focused on feeling and showing respect for the patients for whom we cared and encouraging others to do the same.

Measurable improvements had been made by the time I left (4), but after almost a decade at Bellevue, I could no longer bear the near-suicides and patients with fractured bones coming in from Rikers. I was sure that on that island was the root cause of the trauma and learned helplessness among my patients that no treatment in the hospital seemed able to cure. Therefore, I jumped into the jail's health care system as chief of psychiatry to find and try to mend some of those deep wounds.

During my years there, I witnessed such cruelty and neglect that I was at times driven to cursing and tears in front of men with gold stars, and I sought treatment for my own posttraumatic stress disorder (PTSD). I found examples of the insidious and profound effects of law-and-order policies, approved by an uninformed or indifferent public, on human beings in confinement. Social workers struggled to keep up with the relentless admission of people who were not dangerous, merely too poor to pay bail. Doctors buckled under the pressure of dual loyalty—the potential conflict between physicians' duty to their patients and the expectations of a confinement system—leading to a young man with progressive muscle weakness being repeatedly dismissed by both jail and hospital, only to be correctly diagnosed just days before requiring intubation. Officers without adequate training or support in the jail's suicidogenic environment watched as a man tied a T-shirt to an exposed pipe and then to his neck, hanging with his feet inches from the floor. Just as at Bellevue, my work was focused on respecting humanity and finding hope.

By the time I left Rikers Island, only 2 weeks before the first known cases of COVID-19 started appearing in the United States, there had been only one suicide in 4 years. New mental health units had been created that are now considered a national model of care. The practice of isolating unusually violent or self-injurious "problematic" people with serious mental illness in dark holding cells had stopped. A list of bright young psychiatrists and psychologists were eager to sign on to the mission. One Friday evening, I stopped at the doorway of a colleague's office to say a quick goodnight. She told me about a young man with intellectual disability who was thriving in one of the new jail mental health units. "He said that this is the nicest place he's ever been in his life," she told me, "and he doesn't want to leave."

Although I felt proud about being part of this progression toward benevolence, I could not help but wonder whether I was also causing harm. In working so hard to improve the quality of mental health treatment in the jails and in joining with a team of devoted doctors who take care of people no one else will, was I justifying the jail as a treatment facility?

"Now, when I talk to medical students and residents, I have the perspective of someone who has ventured into **the secret spaces where society puts the people we fear**"

Outline

1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. Mental Health Care in Jails and Prisons
4. Rethinking Incarceration as a Front Line of Mental Health Care
5. Closing Thoughts

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1. **Mass Incarceration in the United States**
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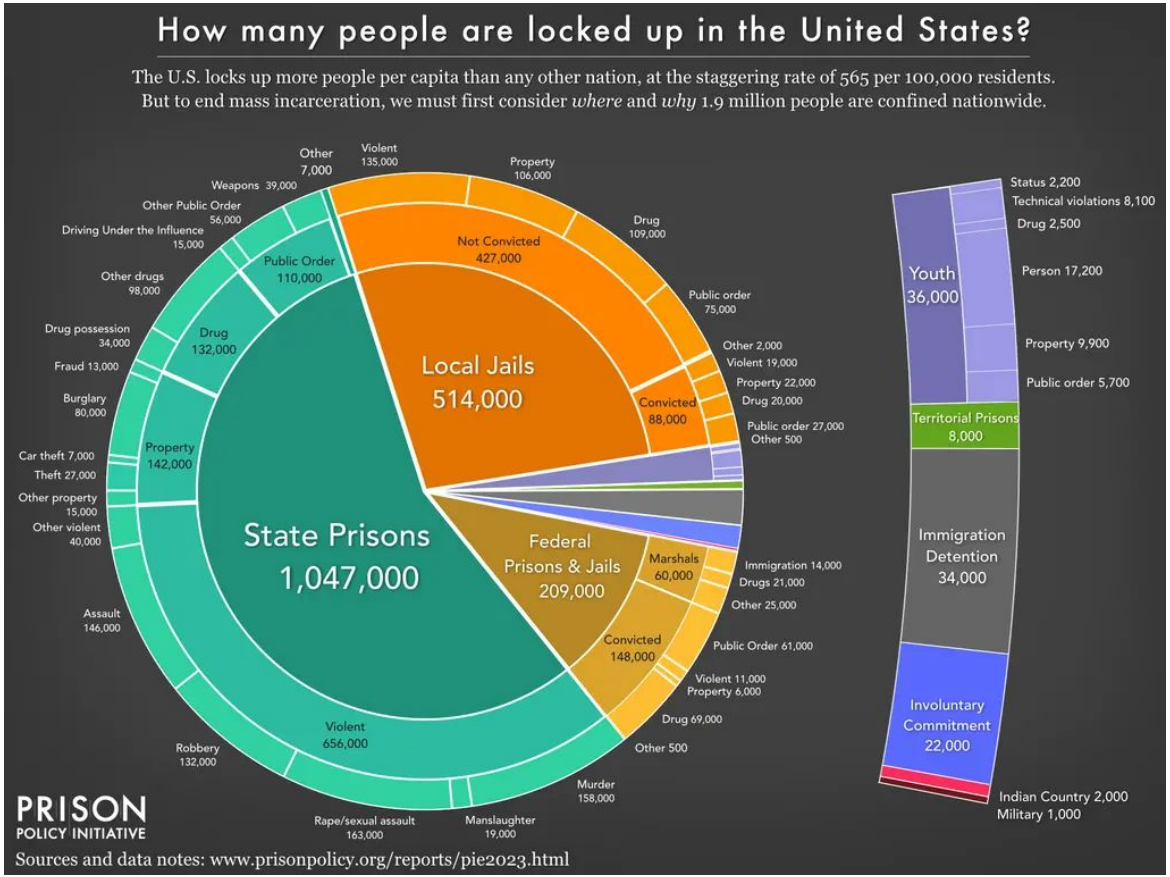
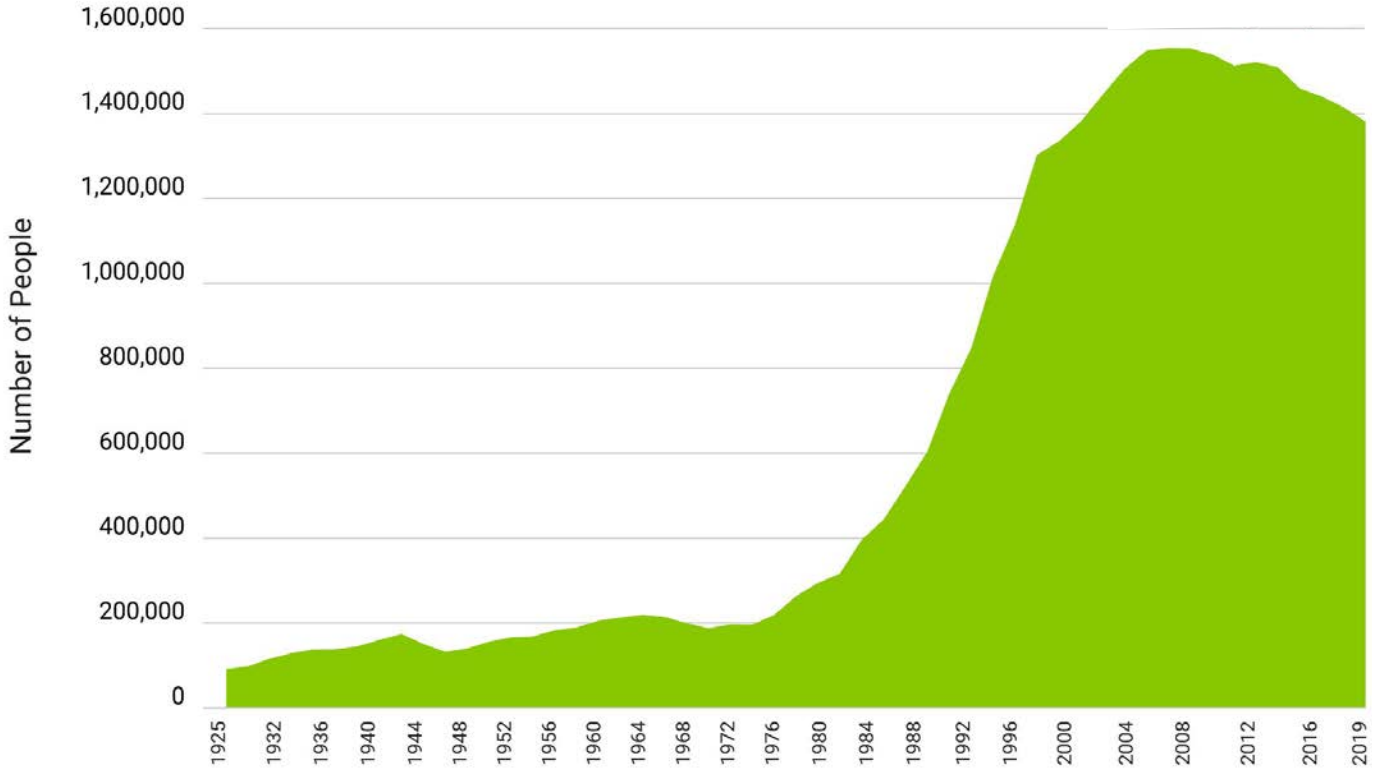

How many people are locked up in the United States?
The U.S. locks up more people per capita than any other nation, at the staggering rate of 565 per 100,000 residents.
But to end mass incarceration, we must first consider *where* and *why* 1.9 million people are confined nationwide.
Local Jails 514,000
Not Convicted 427,000
Convicted 88,000
State Prisons 1,047,000
Public Order 110,000
Drug 132,000
Property 142,000
Violent 656,000
Federal Prisons & Jails 209,000
Marshals 60,000
Convicted 148,000
Other 7,000
Violent 135,000
Property 106,000
Drug 109,000
Public order 75,000
Other 2,000
Violent 19,000
Property 22,000
Drug 20,000
Public order 27,000
Other 500
Immigration 14,000
Drugs 21,000
Other 25,000
Public Order 61,000
Violent 11,000
Property 6,000
Drug 69,000
Other 500
Weapons 39,000
Other Public Order 56,000
Driving Under the Influence 15,000
Other drugs 98,000
Drug possession 34,000
Fraud 13,000
Burglary 80,000
Car theft 7,000
Theft 27,000
Other property 15,000
Other violent 40,000
Assault 146,000
Robbery 132,000
Rape/sexual assault 163,000
Manslaughter 19,000
Murder 158,000
Youth 36,000
Status 2,200
Technical violations 8,100
Drug 2,500
Person 17,200
Property 9,900
Public order 5,700
Territorial Prisons 8,000
Immigration Detention 34,000
Involuntary Commitment 22,000
Indian Country 2,000
Military 1,000
PRISON POLICY INITIATIVE
Sources and data notes: www.prisonpolicy.org/reports/pie2023.html

THE SENTENCING PROJECT

U.S. State and Federal Prison Population, 1925-2019



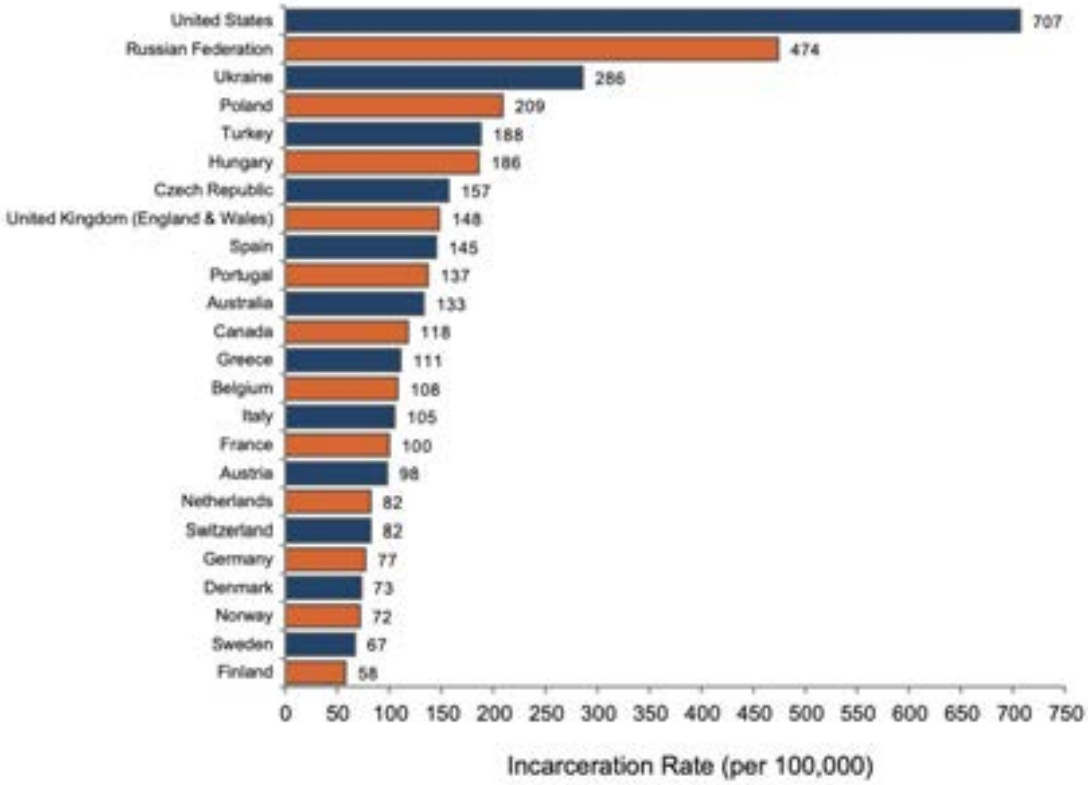
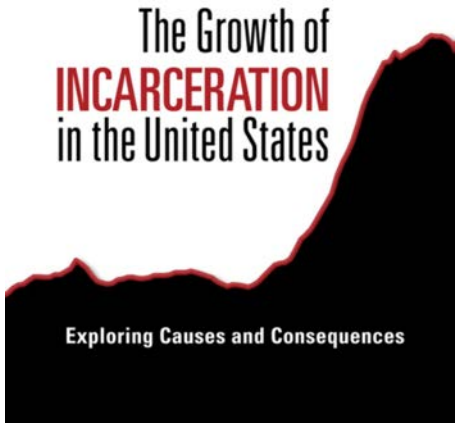


FIGURE 2-2 Incarceration rates per 100,000 population of European and selected common law countries.
NOTES: Rate estimates vary slightly from those of other sources for the United States. Year of reporting for the United States is 2012; years for other nations range from 2011 to 2013.
SOURCE: International Centre for Prison Studies (2013).



SOCIUS

Original Article

What Percentage of Americans Have Ever Had a Family Member Incarcerated?: Evidence from the Family History of Incarceration Survey (FamHIS)

Peter K. Enns[1], Youngmin Yi[1], Megan Comfort[2], Alyssa W. Goldman[1], Hedwig Lee[3], Christopher Muller[4], Sara Wakefield[5], Emily A. Wang[6], and Christopher Wildeman[1,7]

ASA
AMERICAN SOCIOLOGICAL ASSOCIATION

Socius: Sociological Research for a Dynamic World
Volume 5: 1–45

DOI: 10.1177/2378023119829332
srd.sagepub.com
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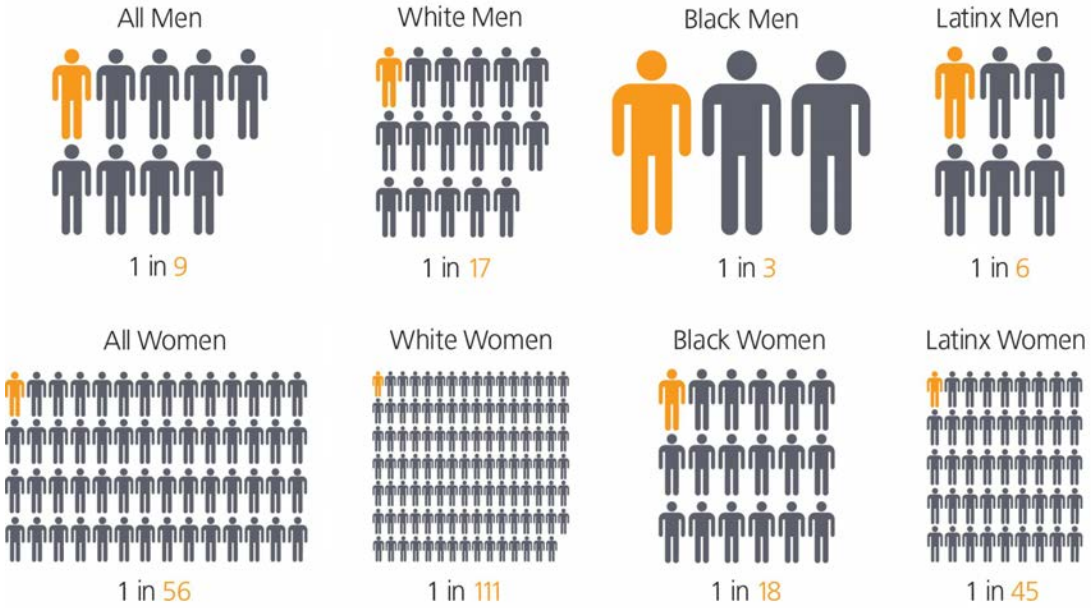
"The data show that **45 percent of Americans have ever had an immediate family member incarcerated**."

"The incarceration of an immediate family member was most prevalent for blacks (63 percent) but common for whites (42 percent) and Hispanics (48 percent) as well."

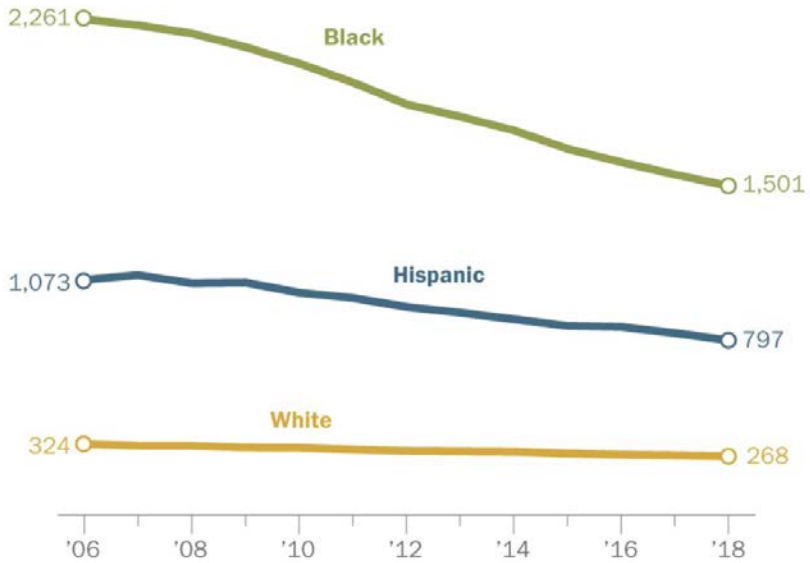
Lifetime Likelihood of Imprisonment of U.S. Residents Born in 2001



THE SENTENCING PROJECT

Imprisonment rates have declined across racial and ethnic groups – especially among black Americans

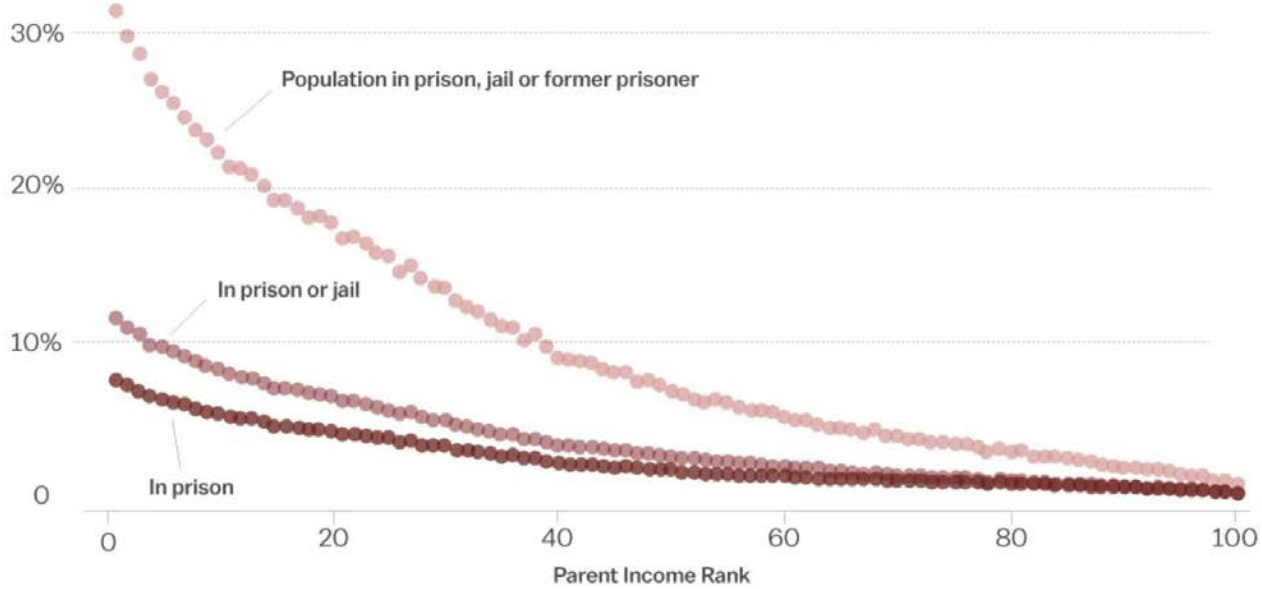
Prisoners per 100,000 adults ages 18 and older in each group



Notes: Blacks and whites include those who report being only one race and are non-Hispanic. Hispanics are of any race. Prisoners are those sentenced to more than a year in state or federal prison.
Source: Bureau of Justice Statistics.

PEW RESEARCH CENTER

Fraction of men in prison, in jail or prison, or in prison, jail, or a former prisoner, by parent income



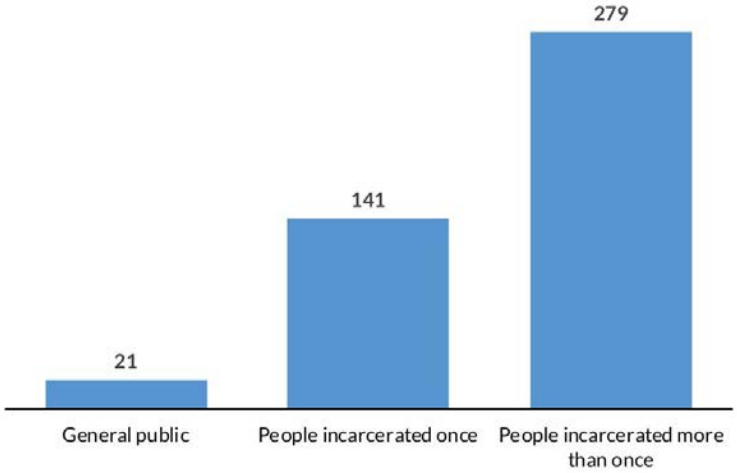
Note: Figure shows the estimated share of individuals born between 1980-1986 who are in prison, in prison or jail, or in prison, jail, or a former prisoner. "In prison" is the share observed in prison serving a sentence of one year or greater in IRS records. "In prison or jail" is an estimate of the total incarceration rate (in pris-on or in jail) based on the share of the 1980-1986 birth cohorts incarcerated in an adult correctional facility in the 2014 5-year American Community Survey. "In prison, in jail, or former prisoner" is the sum of the ACS-estimated rate plus the number of former prisoners estimated by Bucknor and Barber 2016 and as-signed in proportion to the number of individuals in prison observed in the IRS sample.
Source: Brookings Institution / Adam Looney and Nicholas Turner

Vox

Christina Animashaun/Vox

People Incarcerated More Than Once Are 13 Times More Likely to Experience Homelessness Than the General Public

Number of people experiencing homelessness per 10,000 people in 2008



Source: Lucius Couloute, "Nowhere to Go: Homelessness among formerly incarcerated people," Prison Policy Initiative, August 2018, https://www.prisonpolicy.org/reports/housing.html.
Notes: Homelessness rates for the general public come from the Prison Policy Initiative's analysis of US Department of Housing and Urban Development homeless counts and US Census Bureau population estimates for 2008. Homelessness rates for formerly incarcerated people come from the Prison Policy Initiative's analysis of the National Former Prisoner Survey conducted in 2008.

URBAN INSTITUTE

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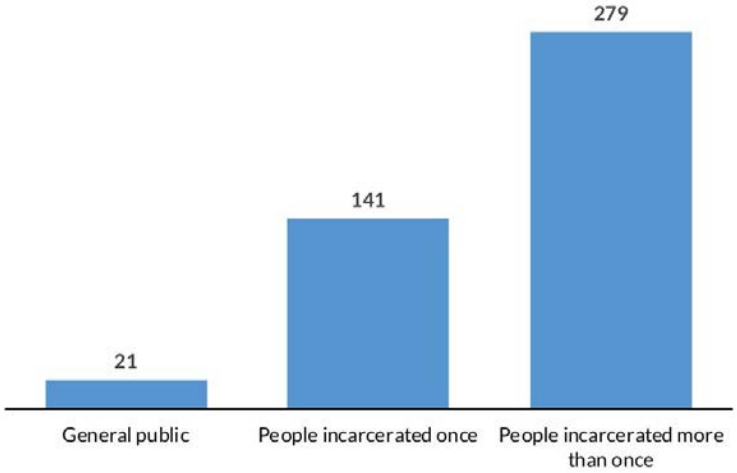

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URBAN INSTITUTE

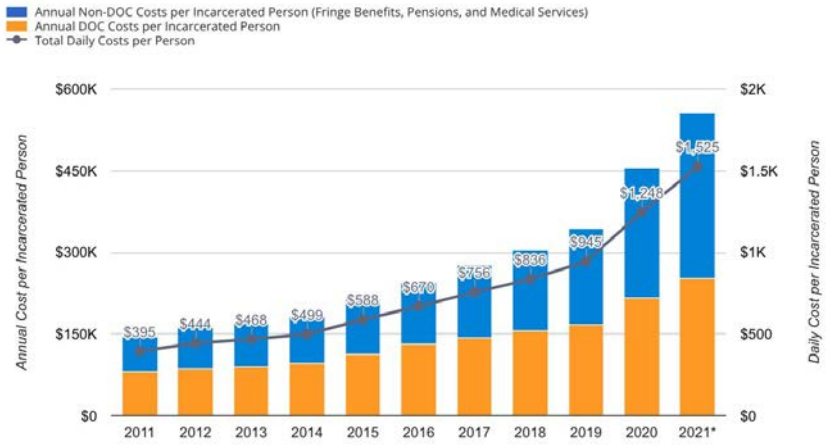
Estimated Criminal Justice System Involvement and Mental Illness among the Unsheltered Homeless in California, 2017

	Estimate	Percent of Unsheltered Homeless Population
Ever Incarcerated	64,149	70%
Recently Incarcerated	25,660	28%
Presently Justice Involved	11,913	13%
Ever Incarcerated Reporting Mental Health Issues	29,692	32%
Ever Incarcerated Reporting a Serious Mental Illness	13,746	15%

California Health Policy Strategies, 2018

Full Annual Cost per Incarcerated Person Nearly Quadrupled Since FY11

Total Annual and Daily Cost per Incarcerated Person, Including Costs Funded Outside the Department of Correction Budget

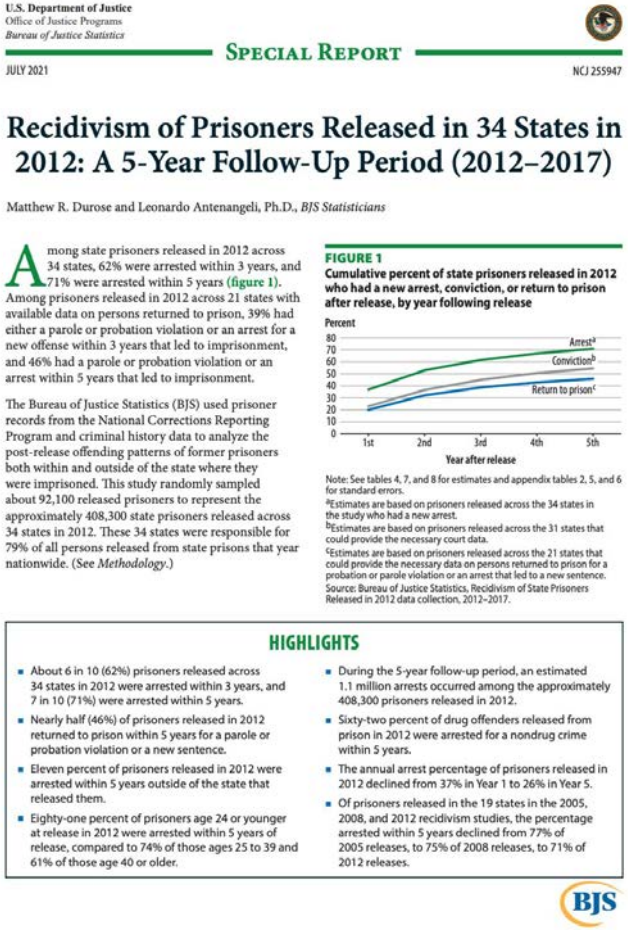


*Fringe benefit and pension costs are estimated as of April 2021.

Full cost excludes debt service, judgments and claims, and legal services. DOC costs related to staffing the Horizon Juvenile Detention Center were also excluded. In FY 2020, debt service added daily costs of $73 per incarcerated person, and tort claim settlements and judgments added $16 per incarcerated person per day. Fringe benefits include the cost of retiree health insurance.

Source: NYC Comptroller Annual Comprehensive Financial Reports for FY 2011 – 2021, NYC Office of Management and Budget Message of the Mayor and Budget Function Analysis for FY 2012 – 2022, NYC Financial Management System, Mayor's Management Reports for FY 2011 – 2021.

"The City now spends $556,539 to incarcerate one person for a full year, or $1,525 per day – nearly quadrupling since FY 2011"



U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

SPECIAL REPORT

JULY 2021 NCJ 255947

Recidivism of Prisoners Released in 34 States in 2012: A 5-Year Follow-Up Period (2012–2017)

Matthew R. Durose and Leonardo Antenangeli, Ph.D., *BJS Statisticians*

Among state prisoners released in 2012 across 34 states, 62% were arrested within 3 years, and 71% were arrested within 5 years (figure 1). Among prisoners released in 2012 across 21 states with available data on persons returned to prison, 39% had either a parole or probation violation or an arrest for a new offense within 3 years that led to imprisonment, and 46% had a parole or probation violation or an arrest within 5 years that led to imprisonment.

The Bureau of Justice Statistics (BJS) used prisoner records from the National Corrections Reporting Program and criminal history data to analyze the post-release offending patterns of former prisoners both within and outside of the state where they were imprisoned. This study randomly sampled about 92,100 released prisoners to represent the approximately 408,300 state prisoners released across 34 states in 2012. These 34 states were responsible for 79% of all persons released from state prisons that year nationwide. (See *Methodology*.)

FIGURE 1
Cumulative percent of state prisoners released in 2012 who had a new arrest, conviction, or return to prison after release, by year following release

Note: See tables 4, 7, and 8 for estimates and appendix tables 2, 5, and 6 for standard errors.
[a]Estimates are based on prisoners released across the 34 states in the study who had a new arrest.
[b]Estimates are based on prisoners released across the 31 states that could provide the necessary court data.
[c]Estimates are based on prisoners released across the 21 states that could provide the necessary data on persons returned to prison for a probation or parole violation or an arrest that led to a new sentence.
Source: Bureau of Justice Statistics, Recidivism of State Prisoners Released in 2012 data collection, 2012–2017.

HIGHLIGHTS

- About 6 in 10 (62%) prisoners released across 34 states in 2012 were arrested within 3 years, and 7 in 10 (71%) were arrested within 5 years.
- Nearly half (46%) of prisoners released in 2012 returned to prison within 5 years for a parole or probation violation or a new sentence.
- Eleven percent of prisoners released in 2012 were arrested within 5 years outside of the state that released them.
- Eighty-one percent of prisoners age 24 or younger at release in 2012 were arrested within 5 years of release, compared to 74% of those ages 25 to 39 and 61% of those age 40 or older.
- During the 5-year follow-up period, an estimated 1.1 million arrests occurred among the approximately 408,300 prisoners released in 2012.
- Sixty-two percent of drug offenders released from prison in 2012 were arrested for a nondrug crime within 5 years.
- The annual arrest percentage of prisoners released in 2012 declined from 37% in Year 1 to 26% in Year 5.
- Of prisoners released in the 19 states in the 2005, 2008, and 2012 recidivism studies, the percentage arrested within 5 years declined from 77% of 2005 releases, to 75% of 2008 releases, to 71% of 2012 releases.

BJS

Among people released from prisons across 34 states in 2012, **7 in 10 (71%) were arrested within 5 years**

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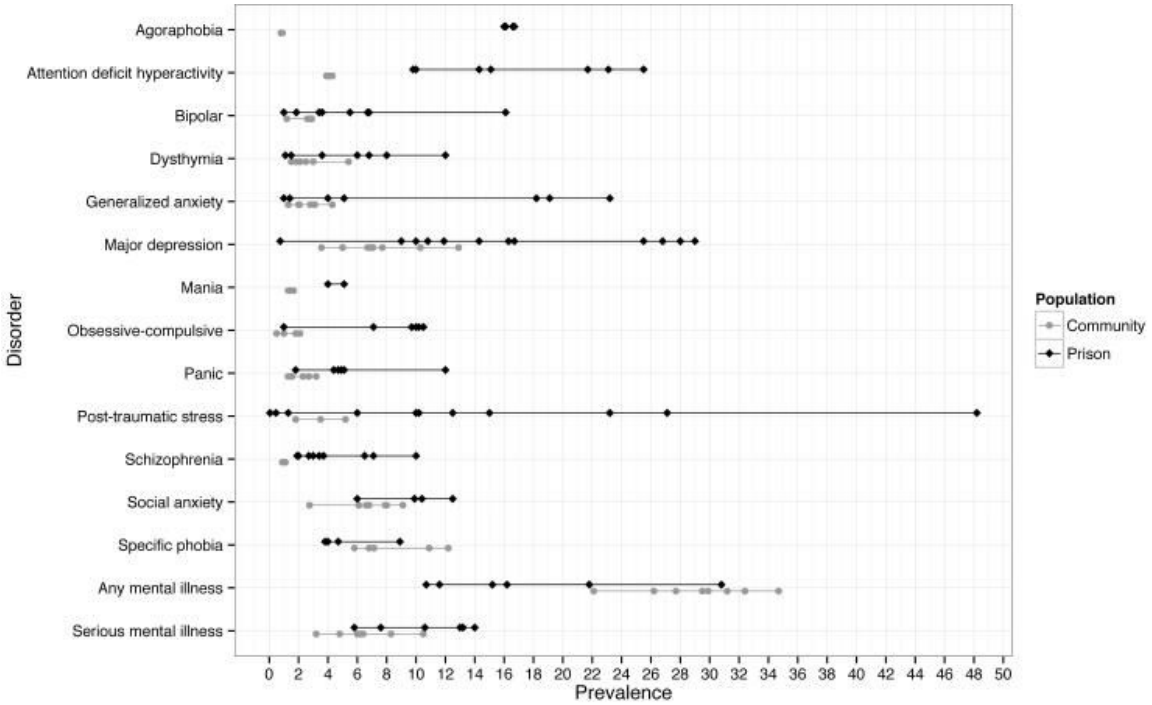
The Prevalence of Mental Illnesses in U.S. State Prisons: A Systematic Review

Seth J. Prins, MPH



Psychiatric Services 2014; 65(7):862-872

A BACKGROUND PAPER FROM THE
OFFICE OF RESEARCH
& PUBLIC AFFAIRS

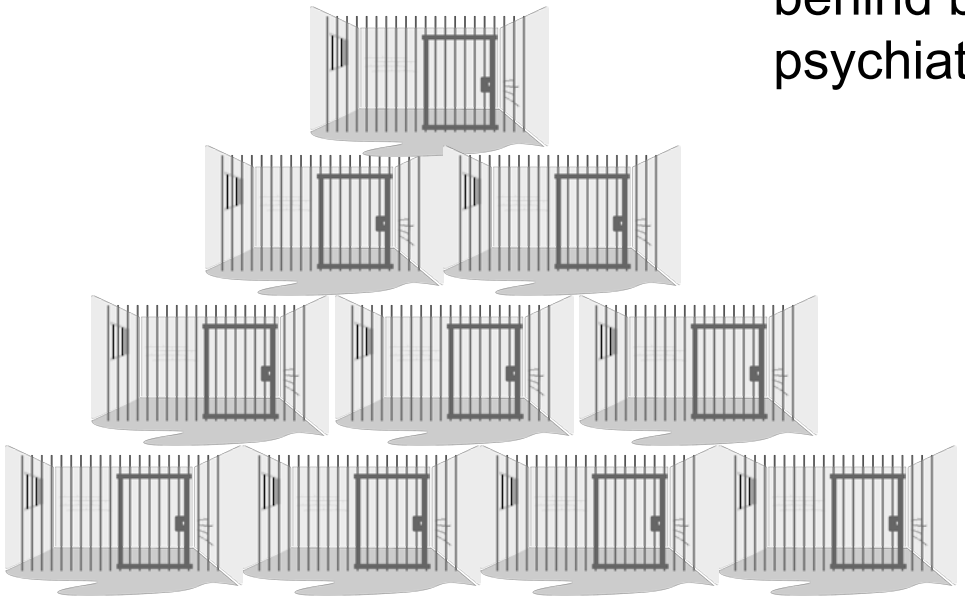
CRIMINALIZATION

September 2016

Serious Mental Illness (SMI) Prevalence in Jails and Prisons

- ~15-20% of people incarcerated in jails or state prisons have SMI

- ~10x more people with SMI behind bars than in state psychiatric hospitals



Los Angeles Times

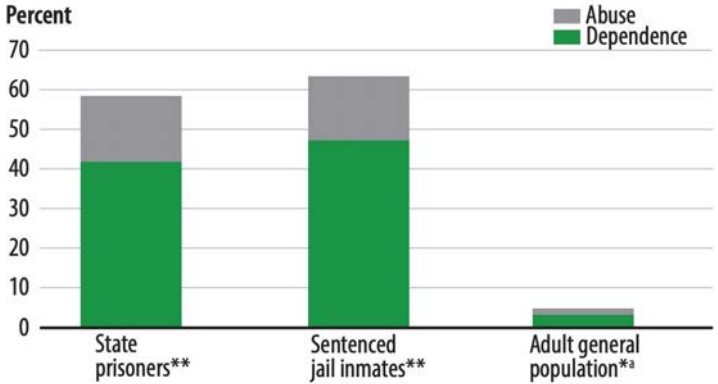
Tyler LaRiviere / Sun-Times

Bebeto Matthews / AP Photo

"The Los Angeles County Jail, Chicago's Cook County Jail, or New York's Rikers Island Jail Complex each hold **more mentally ill inmates than any remaining psychiatric hospital** in the United States"

FIGURE 1

Inmates and adult general population who met the criteria for drug dependence or abuse, 2007–2009



Note: See *Methodology* for definition of dependence and abuse based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. See appendix table 1 for standard errors.

*Comparison group.

**Difference with the comparison group is significant at the 95% confidence level.

[a]General population estimates have been standardized to the state prisoner population by sex, race, Hispanic origin, and age.

Source: Bureau of Justice Statistics, National Inmate Surveys, 2007 and 2008–09; and Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health, 2007–2009.

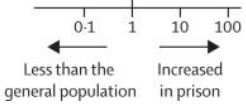
Bronson et al., BJS 2017

Suicide in prisons: an international study of prevalence and contributory factors

Seena Fazel, Taanvi Ramesh, Keith Hawton

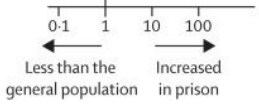
A Men

	RR (95% CI)	p value
Croatia	0·5 (0·0–7·3)	0·54
Northern Ireland	0·5 (0·0–23·8)	0·63
USA	1·6 (1·4–1·8)	<0·0001
Scotland	1·7 (0·7–4·1)	0·24
Czech Republic	1·9 (1·0–3·5)	0·065
Ireland	2·0 (0·5–8·2)	0·34
Belgium	2·0 (1·1–4·0)	0·0241
New Zealand	3·4 (1·5–8·1)	0·0045
Finland	3·5 (1·2–10·5)	0·0234
Spain	3·7 (2·4–5·6)	<0·0001
Iceland	3·7 (0·1–191·9)	0·51
England and Wales	3·9 (3·1–5·0)	<0·0001
Denmark	4·2 (1·4–12·7)	0·0107
Germany	4·2 (3·2–5·6)	<0·0001
Sweden	5·4 (2·4–11·9)	<0·0001
Netherlands	5·6 (3·0–10·3)	<0·0001
France	5·7 (4·7–6·9)	<0·0001
Portugal	6·5 (3·7–11·2)	<0·0001
Italy	7·7 (5·8–10·2)	<0·0001
Norway	10·2 (4·6–22·7)	<0·0001



B Women

	RR (95% CI)	p value
USA	3·7 (2·6–5·4)	<0·0001
New Zealand	6·6 (0·1–338·2)	0·35
Czech Republic	7·2 (0·4–116·3)	0·16
Sweden	8·3 (0·2–421·5)	0·29
Spain	8·7 (1·5–50·3)	0·0159
England and Wales	8·9 (2·2–35·6)	0·0021
Netherlands	10·6 (0·7–169·4)	0·10
Germany	11·9 (4·0–35·5)	<0·0001
Belgium	12·2 (1·3–117·9)	0·0302
Norway	16·7 (0·3–848·3)	0·1605
Scotland	17·4 (2·4–124·7)	0·0045
Italy	20·5 (4·1–101·9)	0·0003
Denmark	30·3 (0·6–1541·8)	0·089
Portugal	33·6 (5·7–196·7)	0·0001
France	41·3 (20·6–82·8)	<0·0001
Northern Ireland	160·7 (16·3–1580·3)	<0·0001



Lancet Psychiatry 2017;
4: 946–52

Prevalence of Medical Conditions among Federal and State Prisoners, Jail Inmates, and the Noninstitutionalized U.S. Population.*

Condition	Federal Inmates	State Inmates	Jail Inmates	U.S. Population
		percent		
Any chronic medical condition	38.5	42.8	38.7	NA
Diabetes mellitus	11.1	10.1	8.1	6.5
Hypertension	29.5	30.8	27.9	25.6
Prior myocardial infarction	4.5	5.7	2.1	3.0
Persistent kidney problems	6.3	4.5	4.1	NA
Persistent asthma	7.7	9.8	8.6	7.5
Persistent cirrhosis	2.2	1.8	1.8	NA
Persistent hepatitis	4.6	5.7	4.6	NA
HIV infection	0.9	1.7	1.6	0.5
Symptoms of mental health disorders	39.8	49.2	60.5	10.6
Major depressive disorder	16.0	23.5	29.7	7.9
Mania disorder	35.1	43.2	54.5	1.8
Psychotic disorder	10.2	15.4	23.9	3.1

* Data are from the Bureau of Justice Statistics and a 2009 study from the Cambridge Health Alliance. NA denotes not available.

Rich et al., NEJM 2011

The Dose–Response of Time Served in Prison on Mortality: New York State, 1989–2003

Evelyn J. Patterson, PhD

Objectives. I investigated the differential impact of the dose–response of length of stay on postprison mortality among parolees.

Methods. Using 1989–2003 New York State parole administrative data from the Bureau of Justice Statistics on state correctional facilities, I employed multinomial logistic regression analyses and formal demographic techniques that used the life table of the populations to deduce changes in life expectancy.

Results. Each additional year in prison produced a 15.6% increase in the odds of death for parolees, which translated to a 2-year decline in life expectancy for each year served in prison. The risk was highest upon release from prison and declined over time. The time to recovery, or the lowest risk level, was approximately two thirds of the time served in prison.

Conclusions. Incarceration reduces life span. Future research should investigate the pathways to this higher mortality and the possibilities of recovery. (*Am J Public Health.* 2013;103:523–528. doi:10.2105/AJPH.2012.301148)

RESEARCH AND PRACTICE

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Objectives. I investigated the differential impact of the dose–response of length of stay on postprison mortality among parolees.

Methods. Using 1989–2003 New York State parole administrative data from the Bureau of Justice Statistics on state correctional facilities, I employed multinomial logistic regression analyses and formal demographic techniques that used the life table of the populations to deduce changes in life expectancy.

Results. Each additional year in prison produced a 15.6% increase in the odds of death for parolees, which translated to a 2-year decline in life expectancy for each year served in prison. The risk was highest upon release from prison and declined over time. The time to recovery, or the lowest risk level, was approximately two thirds of the time served in prison.

Conclusions. Incarceration reduces life span. Future research should investigate the pathways to this higher mortality and the possibilities of recovery. (*Am J Public Health.* 2013;103:523–528. doi:10.2105/AJPH.2012.301148)

Original Investigation | Public Health

May 28, 2021

Exposure to Family Member Incarceration and Adult Well-being in the United States

Ram Sundaresh, MD, MS[1]; Youngmin Yi, PhD[2]; Tyler D. Harvey, MPH[3]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2021;4(5):e2111821. doi:10.1001/jamanetworkopen.2021.11821

Key Points

Question Is the incarceration of a family member associated with well-being and projected life expectancy?

Findings In this cross-sectional study including 2815 individuals, any family member incarceration was associated with lower well-being and a projected 2.6-year reduction in life expectancy compared with no family member incarceration experience. Among those with any family incarceration, Black respondents had an estimated 0.5 fewer years of projected life expectancy compared with White respondents.

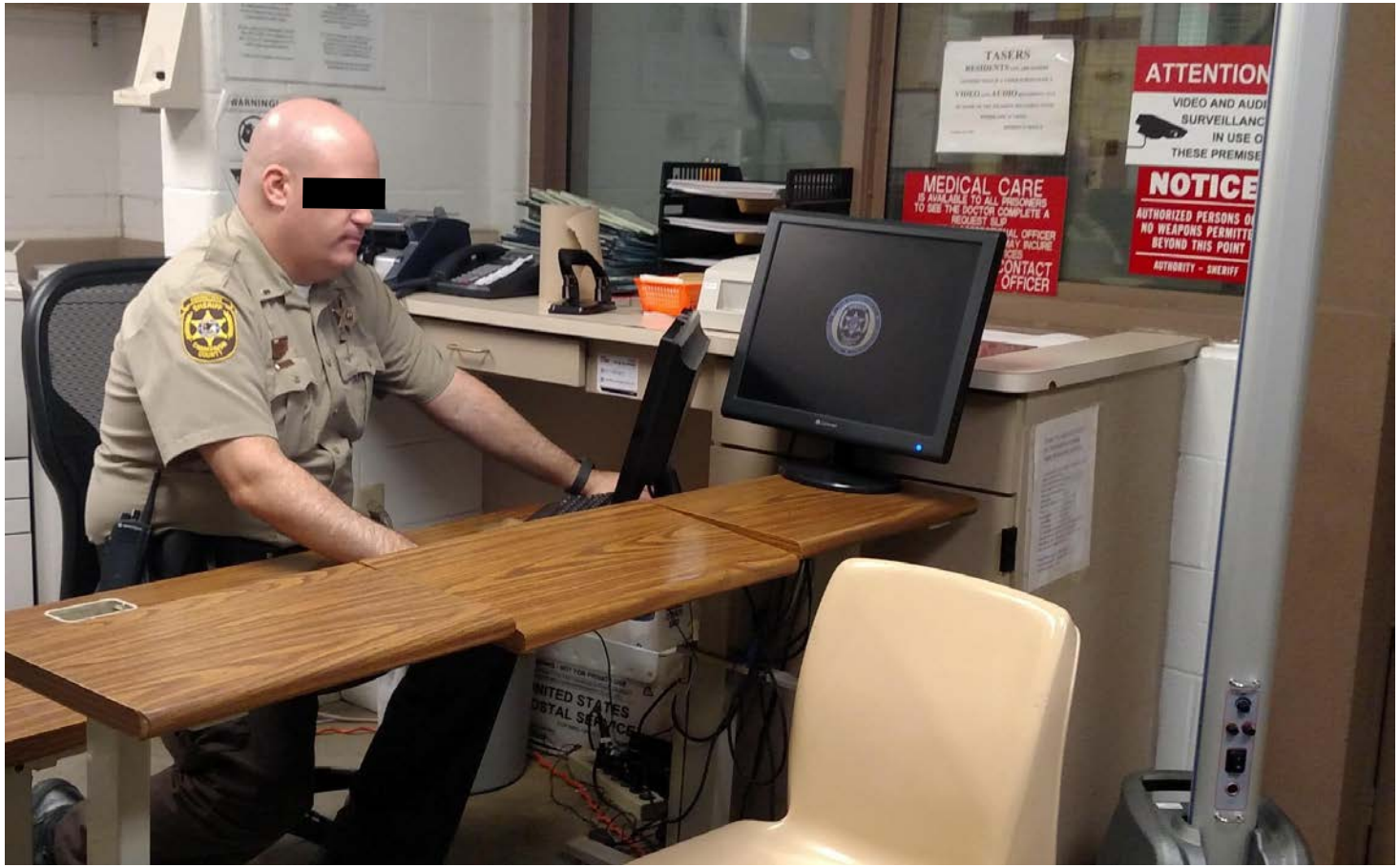
Meaning These findings suggest that efforts to decarcerate may improve population-level health and well-being by reducing racial disparities and detrimental outcomes associated with incarceration for nonincarcerated family members.

Outline

1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. **Mental Health Care in Jails and Prisons**
4. Rethinking Incarceration as a Frontline of Mental Health Care
5. Closing Thoughts

Outline

1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. **Mental Health Care in Jails and Prisons**
    a. **Opportunities for Providing Care**
    b. Challenges in Providing Care
4. Rethinking Incarceration as a Front Line of Mental Health Care
5. Closing Thoughts



Christine Herman / Illinois Public Media

Trent Nelson / The Salt Lake Tribune

Elise Amendola/AP

PERSPECTIVES

Mental Health Units in Correctional Facilities in the United States

Talia R. Cohen, BA, Christin A. Mujica, BS, Margaret E. Gardner, BS, Melissa Hwang, BS, and Rakesh Karmacharya, MD, PhD

Background: The prevalence of severe mental illness (SMI) in correctional settings is alarmingly high. Some correctional facilities have developed mental health units (MHUs) to treat incarcerated individuals with SMI.

Objective: To identify existing MHUs in the United States and collate information on these units.

Data Sources: A systematic review using Criminal Justice Abstracts, ERIC, PsycINFO, PubMed, and SocINDEX, plus an exploratory review using the Google search engine were conducted. MHUs were included if they were located within an adult correctional facility in the United States, specifically catered to SMI populations, and were in active operation as of June 2019.

Results: Eleven articles were identified through the peer-reviewed literature, but there were still major gaps in the information on MHUs. The Google search identified 317 MHUs. The majority of units were located within prisons (79.5%) and served only men (76%). The Google search found information indicating that 169 (53.3%) offered groups or programming to inmates; 104 (32.8%) offered individual therapy; and 89 (23%) offered both. One hundred sixty-six units (52.4%) had dedicated mental health staff, and 75 (23.7%) provided mental health training to correctional officers. Information on funding and outcomes of the MHUs is presented.

Limitations: Use of the Google search engine and sources that have not been peer reviewed limits the robustness of conclusions about the MHUs.

Conclusions: Standards for developing and implementing MHUs are not widespread. The shortcomings of current MHUs are discussed in the context of desired criteria for size, staffing, and programming.

Keywords: jail, prison, incarceration, mental health unit, recidivism

Yen Duong / NC Health News

Julie Jacobson / AP

Hensel Philips

Hensel Philips

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TREATMENTS

Most Inmates With Mental Illness Still Wait For Decent Care

February 3, 2019 · 7:00 AM ET

CHRISTINE HERMAN

FROM Illinois Public Media

The Joliet Treatment Center, southwest of Chicago, is one of four facilities now providing mental health care to some of Illinois' sickest inmates. It's a start, say mental health advocates, but many more inmates in Illinois and across the U.S. still await treatment.

Christine Herman/Illinois Public Media

Ashoor Rasho has spent more than half his life alone in a prison cell in Illinois — 22 to 24 hours a day. The cell was so narrow he could reach his arms out and touch both walls at once.

"It was pretty broke down — the whole system, the way they treated us," says the 43-year-old Rasho, who has been diagnosed with several mental health conditions, including severe depression, schizophrenia and borderline personality disorder.

The Washington Post

Democracy Dies in Darkness

'NO ONE TO TALK YOU DOWN'

Inside federal prisons' dangerous failure to treat inmates with mental-health disorders

Story by **Christie Thompson** and **Taylor Elizabeth Eldridge | The Marshall Project**

NOVEMBER 21, 2018

The voices in John Rudd's head were getting louder. It was April 2017,

THE NEW YORKER

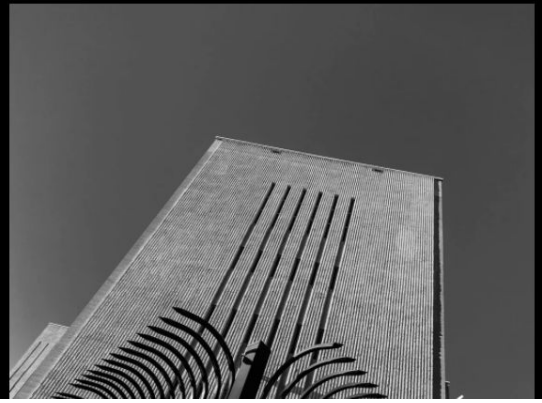
A REPORTER AT LARGE MARCH 4, 2019 ISSUE

THE JAIL HEALTH-CARE CRISIS

The opioid epidemic and other public-health emergencies are being aggravated by failings in the criminal-justice system.

By Steve Coll

February 25, 2019



HPSA Find

The Health Professional Shortage Area (HPSA) Find tool displays data on the geographic, population, and facility HPSA designations throughout the U.S. To determine National Health Service Corps (NHSC) site eligibility please contact HRSA at http://www.hrsa.gov/about/contact/bhwhelp.aspx or call 1-800-221-9393.

Search | HPSA ID Search

Export Data XLSX PDF

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California

Select County(s) (required)

El Dorado County
Fresno County
Glenn County
Humboldt County
Imperial County
Inyo County
Kern County
Kings County
Lake County
Lassen County

Submit

Apply Filters (Optional)

HPSA Discipline

- [ ] Primary Care
- [ ] Dental Health
- [x] Mental Health

Discipline	HPSA ID	HPSA Name	Designation Type	Primary State Name	County Name	HPSA FTE Short	HPSA Score	Status	Rural Status	Designation Date	Update Date
Mental Health	7061657127	Avenal State Prison	Correctional Facility	California	Kings County, CA	2.73	24	Designated	Rural	08/30/2000	07/05/2018
Mental Health	7067940507	California Correctional Center-Lassen County	Correctional Facility	California	Lassen County, CA	2.88	12	Designated	Rural	03/06/2005	07/05/2018
Mental Health	7068147015	California Correctional Institution	Correctional Facility	California	Kern County, CA	2.48	21	Designated	Rural	07/07/2016	07/05/2018
Mental Health	7066385970	California State Prison-Calipatria	Correctional Facility	California	Imperial County, CA	1.42	12	Designated	Non-Rural	08/01/2018	08/01/2018
Mental Health	7062697304	Centinela State Prison	Correctional Facility	California	Imperial County, CA	1.26	12	Designated	Rural	07/07/2016	07/05/2018
Mental Health	7066114539	Chuckawalla Valley State Prison	Correctional Facility	California	Riverside County, CA	0.87	15	Designated	Rural	03/06/2005	07/05/2018
Mental Health	7061453201	Correctional Training Facility-Soledad	Correctional Facility	California	Monterey County, CA	0.38	12	Designated	Rural	08/30/2000	07/05/2018

Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity

Jennifer M. Reingle Gonzalez, PhD, and Nadine M. Connell, PhD

Objectives. We assessed mental health screening and medication continuity in a nationally representative sample of US prisoners.

Methods. We obtained data from 18 185 prisoners interviewed in the 2004 Survey of Inmates in State and Federal Correctional Facilities. We conducted survey logistic regressions with Stata version 13.

Results. About 26% of the inmates were diagnosed with a mental health condition at some point during their lifetime, and a very small proportion (18%) were taking medication for their condition(s) on admission to prison. In prison, more than 50% of those who were medicated for mental health conditions at admission did not receive pharmacotherapy in prison. Inmates with schizophrenia were most likely to receive pharmacotherapy compared with those presenting with less overt conditions (e.g., depression). This lack of treatment continuity is partially attributable to screening procedures that do not result in treatment by a medical professional in prison.

Conclusions. A substantial portion of the prison population is not receiving treatment for mental health conditions. This treatment discontinuity has the potential to affect both recidivism and health care costs on release from prison. (*Am J Public Health.* 2014;104:2328–2333. doi:10.2105/AJPH.2014.302043)

Last Days of Solitary / PBS

The New Asylums / PBS

Jason Pohl/Sacramento Bee

John McCoy / Los Angeles Daily News

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    a. **The Quality of Mental Health Services**
5. Closing Thoughts

Incarcerated People are People

Mark Loughney / Karsten Moran / New York Times

AMERICAN PSYCHIATRIC ASSOCIATION

“The fundamental goal of mental health services in a correctional setting is to provide the same level of care to patients in the criminal justice process that **should be available** in the community”

Council on Psychiatry and Law, APA, 2021

Journal of Correctional Health Care
Volume 28, Number 4, 2022

https://doi-org.ucsf.idm.oclc.org/10.1089/jchc.21.08.0072

JOURNAL OF CORRECTIONAL HEALTH CARE

VIEWPOINT

Addressing Shortages of Mental Health Professionals in U.S. Jails and Prisons

Nathaniel P. Morris, MD[1,*] and Matthew L. Edwards, MD[2]

Abstract

Many jails and prisons in the United States do not have enough mental health professionals (MHPs) to meet the mental health needs of the people incarcerated in these facilities. This article examines strategies used to address MHP shortages in U.S. jails and prisons, including compensation incentives, telemental health services, interdisciplinary health care, flexible work schedules, and training rotations in correctional settings. These measures may help alleviate some of the shortages of MHPs in correctional facilities; however, these shortages will likely persist without broader policy reforms that decrease the size of U.S. correctional populations or increase the number of MHPs across the country.

Keywords: correctional facilities, mental health care, shortages, recruitment, incarceration

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Mental disorders and substance use disorders are prevalent among incarcerated populations, typically at higher rates than in the general population (Gottfried & Christopher, 2017; Prins, 2014; Steadman *et al*., 2009). In addition, suicide and self-harm are leading causes of morbidity and mortality among incarcerated people (Favril *et al*., 2020; Fazel *et al*., 2017). However, many U.S. jails and prisons do not have enough mental health professionals (MHPs) to address these mental health needs (Buche *et al*., 2018; Kolodziejczak & Sinclair, 2018; Morris & West, 2020).

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Communication Over Incarceration: Improving Care Coordination Between Correctional and Community Mental Health Services

Nathaniel P. Morris, M.D., and Yaara Zisman-Ilani, Ph.D., M.A.

Millions of people are incarcerated every year in the United States, many of whom have mental disorders and substance use disorders. Alongside the considerable churn of people into and out of U.S. jails and prisons, numerous barriers often impede information exchange between correctional and community mental health services, disrupting continuity of care and threatening the well-being of incarcerated and formerly incarcerated people. This Open Forum examines barriers to information sharing, a critical component of care coordination, between correctional and community mental health services and offers potential solutions to improve continuity of care in these contexts.

Psychiatric Services 2022; 73:1409–1411; doi: 10.1176/appi.ps.202200041

Incarcerated people tend to have high rates of mental disorders and substance use disorders (1), and U.S. correctional facilities manage >8 million admissions annually (2). As a result, incarceration and release back into the community can serve as key transition points in mental health care for millions of people. Alongside this churn of people into and out of U.S. correctional facilities, care coordination between correctional and community mental health services remains a challenge. Legal, technological, and other factors often impede information sharing between correctional and community mental health professionals (MHPs), disrupting continuity of care and threatening the well-being of incarcerated and formerly incarcerated people. This Open Forum examines barriers to information sharing, a critical component of care coordination, between correctional and community mental health services and offers suggestions to improve continuity of care in these contexts. The following case examples are composites and are not representative of actual patient-clinician encounters.

CASE 1: THE COMMUNITY PERSPECTIVE

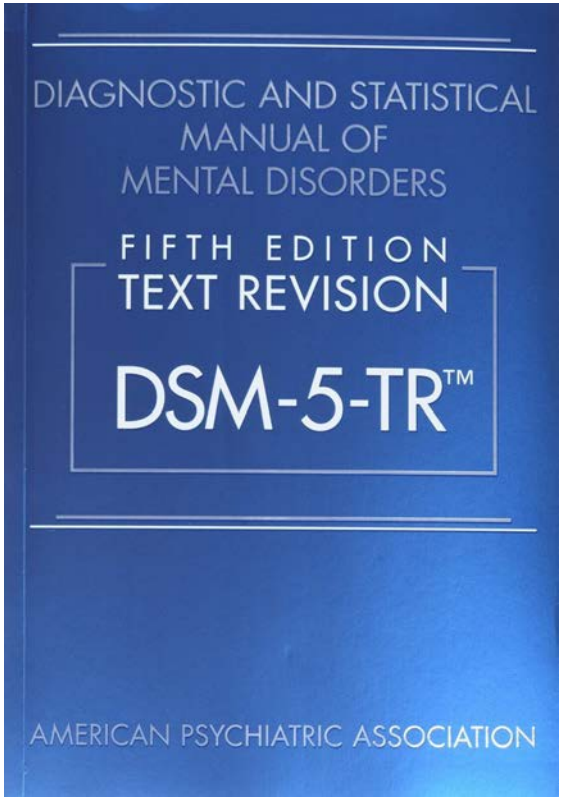
Dr. Y, a community psychiatrist, learns from a patient's family that the patient was recently arrested, and the family does not know where he is being held. Dr. Y searches her clinic's electronic health record (EHR), including outside records, for updates about the patient but sees none. Because the patient is taking clozapine, an antipsychotic with strict prescribing requirements, Dr. Y attempts to contact jail health staff about the patient's care. She finds a website for the county jails, but the website does not list contact information for jail health services. She calls the main jail telephone number, which leads her to various options that do not include health staff. After several calls, she is eventually transferred to a jail health voicemail and leaves a message asking for a callback. She never receives one.

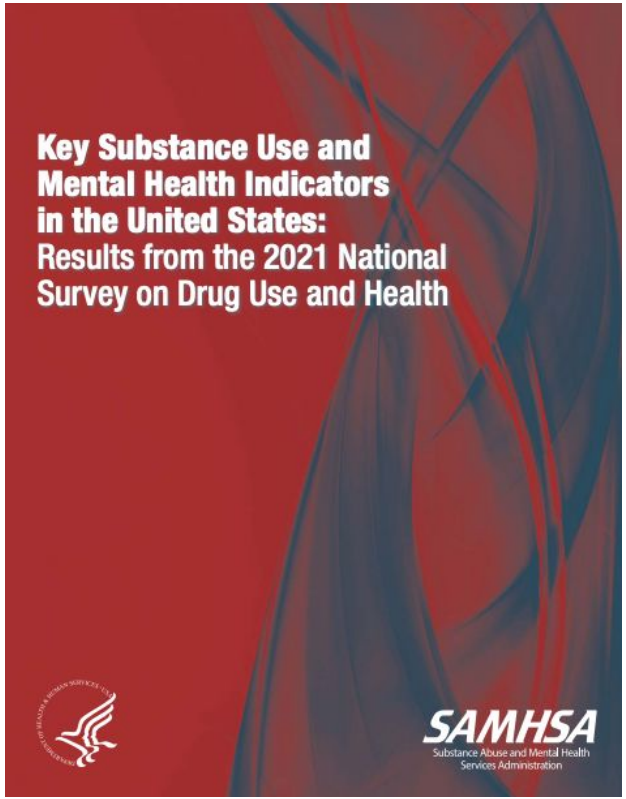
CASE 2: THE CORRECTIONAL PERSPECTIVE

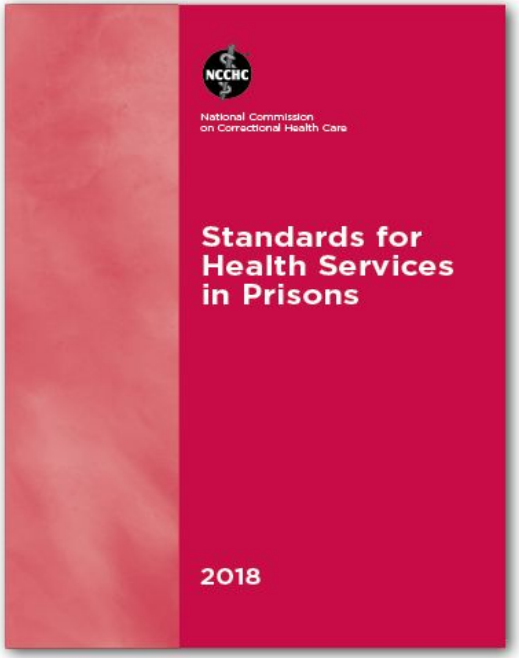
Dr. Z, a jail psychologist, is evaluating an incarcerated patient with symptoms of psychosis. The patient's statements are difficult to understand, but the patient alludes to receiving psychiatric medications from a nearby clinic. Dr. Z calls the clinic to obtain additional information; however, the clinic's front desk staff seem hesitant about speaking to someone from a jail and the legal implications of doing so. Dr. Z reiterates that he is a health professional seeking to coordinate care for treatment purposes, but the clinic staff insist on receiving a release of information (ROI) form signed by the patient before disclosing any information. Dr. Z returns to the patient to complete the paperwork, but the patient is in distress and does not cooperate. Dr. Z is unable to obtain the clinic's information about the patient and must make treatment decisions with limited information.

BARRIERS TO INFORMATION SHARING

Many of the barriers to information exchange between correctional and community mental health settings mirror broader problems in U.S. health care. For example, HIPAA


DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FIFTH EDITION
TEXT REVISION
DSM-5-TR™
AMERICAN PSYCHIATRIC ASSOCIATION


Key Substance Use and
Mental Health Indicators
in the United States:
Results from the 2021 National
Survey on Drug Use and Health
SAMHSA
Substance Abuse and Mental Health
Services Administration



CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

DRUG FORMULARY

August 2021 - V1

Last update on August 12, 2021

CALIFORNIA CORRECTIONAL
HEALTH CARE SERVICES

AAPL Practice Resource for Prescribing in Corrections

1. Statement of Intent

This Practice Resource is intended as a review of the literature and expert opinion, to give guidance and assistance in the provision of psychiatric treatment, with specific reference to psychopharmacology, in correctional facilities. It was developed by correctional psychiatrists with various backgrounds, including clinical administration, system consultations, research, teaching, and direct patient care for inmate patients. Some contributors are actively involved in administration, oversight, and academic endeavors related to psychiatric prescribing in jails and prisons. The process of developing this document incorporated a thorough review that integrated feedback and revisions into the final draft.

The Council of the American Academy of Psychiatry and the Law (AAPL) reviewed and approved the Practice Resource on May 21, 2017. It reflects a consensus among members and experts about the principles and practice of prescribing psychiatric medications in correctional settings. Although recommendations are sometimes articulated when backed by research evidence, ethics standards, or expert opinion, this document should not be construed as dictating the standard of care. Rather, it is intended to inform practice in this area. Practice guidelines published more than five years ago may require updating and are not considered current by the American Psychiatric Association.[1,2] However, this document may cite sections of such practice guidelines when deemed still current, relevant, and applicable to correctional practice. Legal cases cited are jurisdiction specific, and the reader is advised to be aware of local laws and regulations.

All acceptable current ways of performing psychiatric assessment and treatment are not presented herein, and following the recommendations does not lead to a guaranteed outcome. Differing clinical factors, relevant institutional policies, and the psychiatrist's judgment determine how to proceed in individual clinical scenarios. Adherence to the approaches and methods set forth in this document will not ensure any specific outcome. The parameters discussed are not intended to represent all acceptable current or future methods of evaluating inmate patients for medical or mental health disorders and drawing conclusions about the appropriate psychiatric treatment. The Practice Resource is directed toward psychiatrists and other clinicians who are working in a clinical role in conducting evaluations and providing recommendations related to the treatment of mental disorders in a correctional setting. The terms "psychiatrist," "psychiatric provider," and "prescriber" are used interchangeably, but are intended to refer to a professional authorized to provide psychiatric services, including the prescription of medications, in a correctional facility. It is expected that any clinician who agrees to engage in psychiatric assessment and treatment in these settings has appropriate qualifications.

2. Introduction and Legal Framework

Inmates with serious mental illness are overrepresented in correctional facilities, with rates in incarcerated persons ranging from 9 to 20 percent.[3] The consequences of undertreatment of serious mental illness are legion. In the community, these problems have been linked with a greater risk of unemployment, homelessness, emergency medical care, hospitalization, substance use, suicide, being a victim of crime, engaging in violence toward others, and having a poor quality of life.[4,5] The life expectancy of

The American Academy of Psychiatry and the Law acknowledges contributions to this document from Steven Berger, MD, Nickolas Culpepper, MD, Jose Hidalgo, MD, Jerry McKee, PharmD, BCPP, and Hal S. Wormel, MD.

Consultation and review by Jeffrey S. Janofsky, MD, Medical Director, AAPL, are acknowledged.

AAPL Task Force on Prescribing Medication in Corrections: Anthony Tamburello, MD, Jeffrey Metzner, MD, Elizabeth Ferguson, MD, Michael Champion, MD, CCHP, Elizabeth Ford, MD, Graham Glancy, MD, Kenneth Appelbaum, MD, Joseph Penn, MD, CCHP, Kathryn Burns, MD, and Jason Ourada, MD.

Disclosures of financial or other potential conflicts of interest: None.

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Health Care in U.S. Correctional Facilities — A Limited and Threatened Constitutional Right

Marcella Alsan, M.D., Ph.D., M.P.H., Crystal S. Yang, J.D., Ph.D., James R. Jolin, Lucy Tu, and Josiah D. Rich, M.D., M.P.H.

The U.S. Constitution does not guarantee a right to health care. Yet since 1976, the Supreme Court has held that deliberate indifference to the serious medical needs of incarcerated people — a population that is disproportionately sick, poor, and from marginalized racial and ethnic groups — violates the Eighth Amendment's prohibition against cruel and unusual punishment.

What this right means in practice, however, is far from settled, given that the standards for "deliberate indifference" and "serious medical need" are subject to judicial interpretation. Lacking quality standards, robust monitoring, and funding from public medical insurance programs, correctional administrators must provide health care for incarcerated people with limited guidance and often scarce resources. Incarcerated people have little recourse for woefully inadequate medical care except litigation, but they face multiple barriers to accessing the legal system and counsel, and rare wins yield only incremental relief. In the wake of *Dobbs v. Jackson Women's Health Organization*, it is particularly important to elucidate the relevant legal landscape and explore mechanisms for safeguarding the constitutional right to health care in correctional facilities.

INCARCERATION AND ILLNESS

The United States has the world's highest incarceration rate.[1] At the end of 2020, despite historic declines in the incarcerated population due to Covid-19, 1.7 million people in the United States were incarcerated in a state or federal prison or local jail.[2] The risk of incarceration is not evenly distributed across racial and ethnic groups: Black, American Indian or Alaska Native, and Hispanic U.S. residents are approximately 5.1, 4.1, and 2.5 times as likely, respectively, as White residents to be imprisoned.[3] The incarcerated population generally comes from lower-income households, with substantially greater physical and mental health needs than the general population; they have higher rates of tuberculosis, HIV, hepatitis, diabetes, and psychiatric illness.[4] More than half of them have a mental health problem, a substance use disorder, or both, and they experience higher rates of geriatric conditions than the age-matched general population.[4,5] Access to adequate care critically affects this population's health outcomes, as well as U.S. health inequities more broadly.

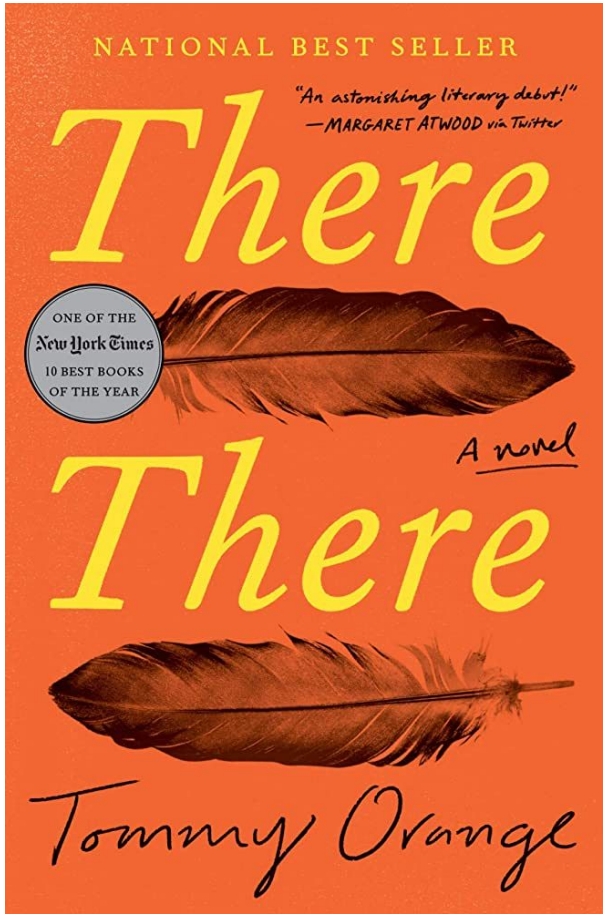
LANDMARK CASES AND LAWS

The constitutional right to correctional health care traces back to the landmark 1976 Supreme Court decision in *Estelle v. Gamble*, which held that failure to provide adequate medical care to incarcerated people as a result of deliberate indifference violates the Eighth Amendment's prohibition against cruel and unusual punishment. Writing for the Court, Justice Thurgood Marshall acknowledged that the primary concern of the amendment's drafters was to bar only "tortur[ous]" and "barbar[ous]" methods of physical punishment. Case law, however, had long construed the Eighth Amendment as embodying "broad and idealistic concepts of dignity, civilized standards, humanity, and decency," leading the Court to examine whether carceral conditions comported with standards of decency. Marshall concluded that "deliberate indifference to the

"guarantee that incarcerated people have an **enforceable, secured right to high-quality health care**"

Outline

1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. Mental Health Care in Jails and Prisons
4. **Rethinking Incarceration as a Front Line of Mental Health Care**
    a. The Quality of Mental Health Services
    b. The Conditions of Confinement
5. Closing Thoughts



"Kids are jumping out the windows of burning buildings, falling to their deaths. **And we think the problem is that they're jumping**."

Los Angeles Times

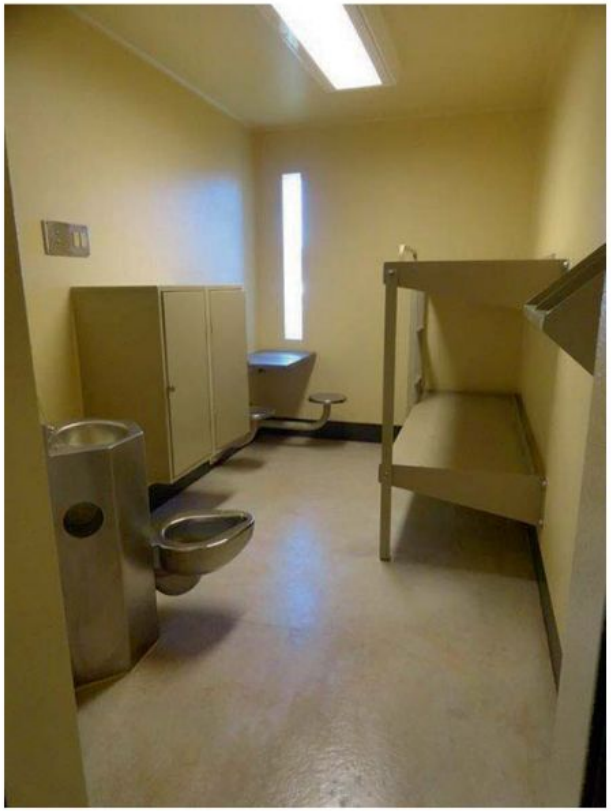


Fig. 3.1 A typical cell at SCI Phoenix. (Source: Authors' collection)

Fig. 3.2 A typical cell at Halden Prison. (Source: Authors' collection)

Hyatt et al., Ch. 3, *The Prison Cell*, 2020

AP Photo / CDCR

Litigation Over Sleep Deprivation in U.S. Jails and Prisons

Nathaniel P. Morris, M.D., Jessica R. Holliday, M.D., M.P.H., Renée L. Binder, M.D.

Incarceration can disrupt healthy sleep, and insomnia is associated with psychiatric symptoms and poor general medical health among incarcerated people. In recent years, considerable litigation has arisen over sleep deprivation in U.S. jails and prisons. This column examines litigation over conditions of incarceration, such as noise, inadequate bedding, constant illumination, medication restrictions, and early wake-up times, that may affect sleep duration and quality. The potential adverse effects of inadequate sleep on incarcerated individuals, as well as associated litigation, suggest the need for policies that reduce unnecessary sleep deprivation and promote healthy sleep in correctional facilities.

Psychiatric Services 2021; 72:1237–1239; doi: 10.1176/appi.ps.202100438

Incarceration can pose numerous challenges to experiencing healthy sleep, including separation from family, stress related to legal proceedings, confinement among strangers, disruptions in health care, safety concerns, and other factors (1, 2). These challenges can reduce sleep quantity and quality, with estimates for the prevalence of insomnia ranging from 11% to 81% in correctional settings (3). Insomnia is associated with psychiatric symptoms, such as anxiety, hostility, and depression, as well as poor general medical health among incarcerated people (3, 4). These associations may be bidirectional (5). Psychiatric and general medical symptoms may cause sleep difficulties; at the same time, research suggests that sleep deprivation might itself contribute to psychotic symptoms, suicidal behaviors, and other adverse outcomes (5–7).

In recent years, incarcerated individuals have pursued considerable litigation related to sleep deprivation in U.S. jails and prisons. This column examines litigation over conditions of incarceration that may affect sleep quality and duration as well as policy implications for correctional facilities.

Noise

Because of overcrowding, movement of people, opening and closing of locked gateways, and additional factors, loud noises in correctional facilities can prevent sleep onset and maintenance. In *Harper v. Showers*, a man contested the conditions of his confinement in a Mississippi prison after an escape attempt. Among other allegations, he claimed that he was "placed in cells next to psychiatric patients who scream, beat on metal toilets, short out the power, flood the cells, throw feces, and light fires, resulting in his loss of sleep for days at a time" (8). In 1999, a federal appellate court reversed, in part, dismissal of the complaint, noting that "sleep undoubtedly counts as one of life's basic needs" and that "conditions designed to prevent sleep, then, might violate the Eighth Amendment" (8). The case was remanded to district court for further proceedings and later dismissed on other grounds.

By comparison, a man who was placed in a federal prison cell with five other men for approximately 28 months filed a civil rights lawsuit over the constant noise as well as unsanitary environment, poor ventilation, extreme temperatures, and other conditions that he described as "horrifying" (9). A district court initially dismissed the case, but the U.S. Court of Appeals for the Second Circuit vacated this decision, in part, noting, inter alia, that "sleep is critical to human existence" and that the complaint "plausibly alleged cruel and unusual punishment" (9). The appellate court remanded the case to district court for further proceedings and, in 2020, a jury awarded $20,000 to the plaintiff. As of October 2020, the case was pending appeal.

HIGHLIGHTS

- Insomnia is common during incarceration and is associated with psychiatric symptoms as well as poor general medical health.
- Considerable litigation has arisen over sleep deprivation in U.S. jails and prisons, including legal actions related to noise, inadequate bedding, constant illumination, medication restrictions, and early wake-up times.
- It is important to develop and implement policies that reduce unnecessary sleep deprivation in correctional facilities.

"No one can argue with the proposition that detainees with medical needs should get their prescriptions, **but why at 2:30am?**"

San Francisco Chronicle e-Edition

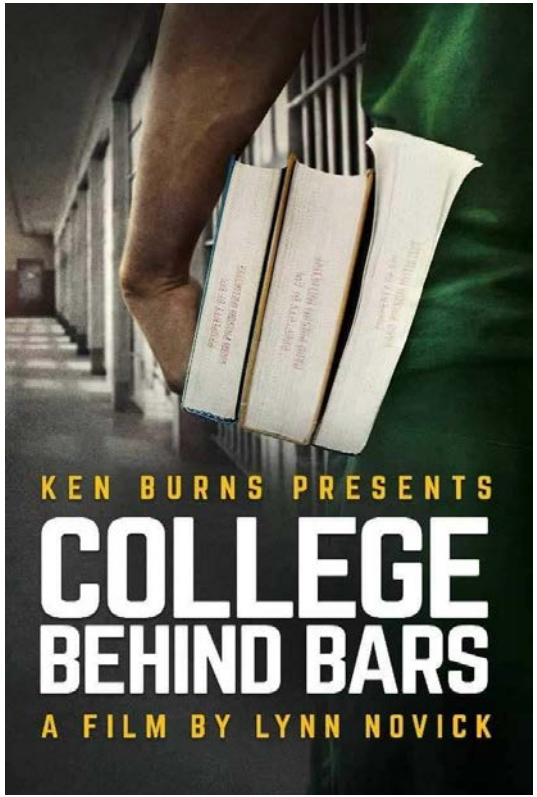
POLITICS

Calls from California prisons will be free under new law signed by Newsom

Bob Egelko
Updated: Sep. 30, 2022 6:49 p.m.

Phones for inmates and visitors are seen at the County Jail 4 in the Hall of Justice in San Francisco on Nov. 1, 2018.
Gabrielle Lurie / The Chronicle

Prisoners in California have had a hard time staying in touch with their families because of the high price of prison phone calls, managed by a $1.4 billion-per-year nationwide industry. But the calls will become free in January under legislation signed by Gov. Gavin Newsom.



NY law requires parents in prison be housed closest to kids

December 24, 2020

ALBANY, N.Y. (AP) — A new bill signed into law in New York will require incarcerated parents be housed in prisons closest to the homes of their children.

More than 100,000 children around the state have at least one parent in prison, many serving time in facilities several hours away from their families.

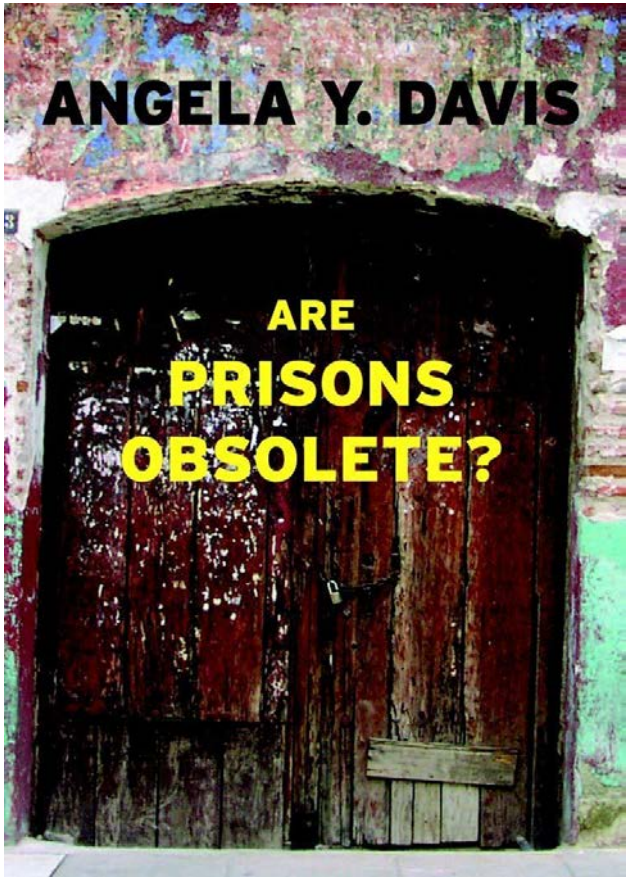
“Children should not be deprived of the opportunity to have a relationship with their parents because of incarceration,” said State Senator Velmanette Montgomery, a Brooklyn Democrat who sponsored the bill.

In-person visitation lowers recidivism rates and is considered a critical factor in whether a family reunites after a prisoner is released, Assemblywoman Nily Rozic, a Queens Democrat, said in announcing the legislation.

The bill passed both houses of the legislature with bipartisan support. Gov. Andrew Cuomo signed it into law Wednesday.

Outline

1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. Mental Health Care in Jails and Prisons
4. **Rethinking Incarceration as a Front Line of Mental Health Care**
    a. The Quality of Mental Health Services
    b. The Conditions of Confinement
    c. Decarceration
5. Closing Thoughts



“The most immediate question today is how to prevent the further expansion of prison populations and **how to bring as many imprisoned women and men as possible back into what prisoners call ‘the free world’**”

The New York Times

In Problem-Solving Court, Judges Turn Therapist

Give this article

By Leslie Eaton and Leslie Kaufman

April 26, 2005 10 MIN READ

CNN health Audio Live TV Log In

Changing the way police respond to mental illness

By Liza Lucas, Special to CNN

Updated 2:02 PM EDT, Wed September 28, 2016

It's official: 2016 was marijuana legalization's biggest year ever

As 2016 ends, one-fifth of the country lives in a state that has legalized marijuana.

By German Lopez | @germanrlopez | german.lopez@vox.com | Dec 29, 2016, 8:30am EST

Federal government releases more than 2,200 people from prison as First Step Act kicks in

Kevin Johnson
USA TODAY

Published 1:41 p.m. ET July 19, 2019 | **Updated 7:01 p.m. ET July 19, 2019**

Pew Research Center

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AUGUST 16, 2021

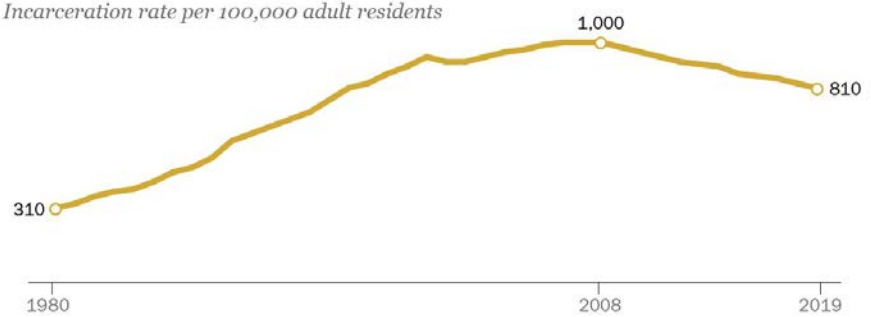
America's incarceration rate falls to lowest level since 1995

BY JOHN GRAMLICH

The U.S. incarceration rate fell in 2019 to its lowest level since 1995, according to recently published data from the Bureau of Justice Statistics (BJS), the statistical arm of the Department of Justice. Despite this decline, the United States incarcerates a larger share of its population than any other country for which data is available.

After decades of sharp growth, incarceration in U.S. has waned

Incarceration rate per 100,000 adult residents



Source: Bureau of Justice Statistics.

Pew Research Center

The New York Times

'Jails Are Petri Dishes': Inmates Freed as the Virus Spreads Behind Bars

Some jails are releasing people to stem outbreaks, but critics say it is not happening quickly enough to save lives and resources.

Cook County Jail in Chicago, where inmates and employees have tested positive for the virus. Santiago Covarrubias/Sun-Times

By Timothy Williams, Benjamin Weiser and William K. Rashbaum

Published March 30, 2020 Updated Nov. 30, 2020

6 MIN READ

U.S. Department of Justice
Office of Justice Programs
Bureau of Justice Statistics

Revised December 20, 2022

SPECIAL REPORT

AUGUST 2022 NCJ 304500

Impact of COVID-19 on State and Federal Prisons, March 2020–February 2021

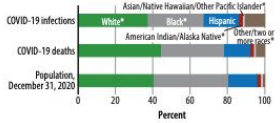
E. Ann Carson, Ph.D., *BJS Statistician*
Melissa Nadel, Ph.D., *Abt Associates*; and Gerry Gaes, Ph.D., *Independent Consultant to Abt Associates*

State and federal correctional facilities performed 4,816,400 viral tests for COVID-19 on persons in prison from the beginning of March 2020 to the end of February 2021. Of these tests, 396,300 (8.2%) were positive for COVID-19, representing 374,400 unique infected persons in state and federal prisons. The infection rate in prisons during this period was 219 per 1,000 state prisoners at risk of exposure to COVID-19 and 298 per 1,000 federal prisoners at risk of exposure.[1] Staff in state correctional facilities had an infection rate of 269 per 1,000 staff, while those working in Federal Bureau of Prisons (BOP) facilities had a rate of 188 per 1,000.

Almost 2,500 state and federal prisoners died of COVID-19-related causes during the 12 months from March 2020 to February 2021. White prisoners accounted for 44% of COVID-19-related deaths in prisons, while black prisoners accounted for 34% (figure 1). Eighty-three percent of COVID-19-related deaths in state and federal prisons occurred in persons age 55 or older.

[1]Total prisoners at risk of exposure to COVID-19 is equal to the number of persons in state or federal prison custody at the end of February 2020 plus those admitted in the following 12 months.

FIGURE 1
Percent of COVID-19 infections and deaths and 2020 yearend population of persons in the custody of state and federal prisons, by race or ethnicity, March 1, 2020–February 28, 2021



Note: Includes positive results of viral (polymerase chain reaction) COVID-19 tests and COVID-19-related deaths among persons held for state or federal correctional authorities in government-operated and privately operated prisons, regardless of sentence status or length. See *Methodology*. Race or ethnicity was missing for almost 10% of COVID-19-infected prisoners and 3% of COVID-19-related deaths. See tables 8 and 10 for percentages. Race and ethnicity data are derived from administrative records and will differ from other published distributions of race and ethnicity in the state and federal prison systems. For the U.S. prison population counts of race and ethnicity, please see *Prisoners in 2020 - Statistical Tables* (NCJ 302776, BJS, December 2021), appendix table 2.

*Excludes persons of Hispanic origin (e.g., "white" refers to non-Hispanic white persons and "black" refers to non-Hispanic black persons).

Source: Bureau of Justice Statistics, National Prisoner Statistics program – Coronavirus Pandemic Supplemental Survey, 2021.

HIGHLIGHTS

- BJS's survey to measure the impact of COVID-19 on U.S. prisons from the end of February 2020 to the end of February 2021 found that the number of persons in the custody of state, federal, or privately operated prisons under state or federal contract decreased more than 16%.
- The prison population declined by 157,500 persons during the first 6 months of the COVID-19 study period through the end of August 2020, and by 58,300 in the 6 months through the end of February 2021.
- Twenty-four states released a total of 37,700 persons from prison on an expedited basis (earlier than scheduled) during the COVID-19 study period.
- State and federal prisons had a crude mortality rate (unadjusted for sex, race or ethnicity, or age) of 1.5 COVID-19-related deaths per 1,000 prisoners from the end of February 2020 to the end of February 2021.
- From the end of February 2020 to the end of February 2021, a total of 196 correctional staff in state and federal prisons died as a result of COVID-19.

BJS

The Marshall Project

SEARCH ABOUT NEWSLETTERS DONATE

NEWS

Jail Populations Creep Back Up After COVID-19

Judges, prosecutors and sheriffs in many states sent people home instead of to jail last year, but new data suggests the change is not lasting.

In Palm Beach County, Florida, the number of people in county jails, including the main detention center pictured here, dropped by nearly 250 during the pandemic. WILFREDO LEE/ASSOCIATED PRESS

By WEIHUA LI, BETH SCHWARTZAPFEL and MICHAEL R. SISAK

Additional reporting by CAMILLE FASSETT

It wasn't long after Matthew Reed shoplifted a $63 set of sheets from a Target in upstate New York that the coronavirus pandemic brought the world to a standstill.

Pew

Many Jails Are As Full As They Were Before COVID-19 Pandemic

As populations rise, localities can benefit from new data and policy resources

ARTICLE

November 17, 2022

By: Julie Wertheimer & Tracy Velázquez

Read time: 3 min

Projects: Public Safety Performance

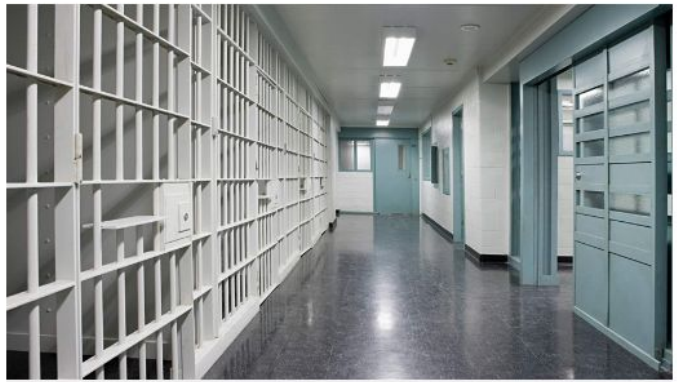


Image Source via Getty Images

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Published in final edited form as:
Int J Prison Health. 2010 December 1; 6(3): 100–106.

Physicians in US Prisons in the Era of Mass Incarceration

Scott A. Allen[1], **Sarah E. Wakeman**[2], **Robert L. Cohen**[3], and **Josiah D. Rich**[1]

"The **medical profession has been complicit in supporting mass incarceration** in the United States, despite the many conflicts with the mission of medicine. Prisons and jails cannot be sustained ethically or constitutionally without the support of the medical profession"

ANALYSIS AND COMMENTARY

Misconceptions About Working in Correctional Psychiatry

Nathaniel P. Morris, MD, and Sara G. West, MD

Incarcerated individuals have high rates of mental disorders and substance use disorders compared with the general population, yet correctional facilities in the United States have difficulty recruiting mental health professionals. This has led to shortages in the availability of clinicians who can provide psychiatric care in these settings. During training and in practice, mental health professionals may develop misconceptions about correctional psychiatry that deter them from the field. This article examines common misconceptions about working in correctional psychiatry, including that correctional psychiatry provides unnecessary care to criminals, supports mass incarceration, is dangerous work, represents a less respectable subspecialty, and excludes clinicians from teaching and research opportunities. This article seeks to provide a resource for mental health professionals considering working with incarcerated patients.

J Am Acad Psychiatry Law 48(2) online, 2020. DOI:10.29158/JAAPL.003921-20

Correctional facilities in the United States often have difficulty hiring and retaining mental health professionals (MHPs), which contributes to profound shortages in the availability of clinicians who can provide psychiatric care in these settings.[1-3] A 2018 survey of 20 corrections representatives from six states found that 85 percent reported difficulty recruiting MHPs to their facilities and 70 percent had "trouble retaining competent behavioral health staff" (Ref. 3, p 6). Broader shortages in the availability of U.S. MHPs compound this problem; for example, a 2018 report found that 54 percent of U.S. counties did not have a single psychiatrist.[4]

Like other institutions that provide health care, correctional facilities may encounter difficulties retaining MHPs over the long term, particularly because MHPs are in demand and may have several options to work elsewhere.[3] Many MHPs, however, are not willing to work in correctional facilities in the first place. In a 2007 study of approximately 170 graduate students at counseling and clinical psychology programs accredited by the American Psychological Association, fewer than 30 percent agreed that they were willing to consider or were planning on a forensic or correctional career.[5] In surveys of 134 Canadian psychiatry residents, conducted between 2009 and 2011, 28 percent agreed with the statement, "I would be likely to try to avoid offering consultation or treatment to individuals in prison" (Ref. 6, p 419). When asked in a 2012 study whether U.S. jails need psychiatrists, 44 residents from a Texas psychiatry residency program responded with a mean score of 84, where 100 indicated total agreement; yet, when asked how likely they were to work in a jail after residency, residents provided a mean response of 22.[7]

During training and in practice, MHPs may develop the following misconceptions that deter them from working in correctional psychiatry:

- Incarcerated patients are less deserving of mental health care than other patients.
- Working in correctional psychiatry supports mass incarceration.
- Correctional psychiatry is more dangerous than practicing psychiatry elsewhere.
- Correctional psychiatry is a less respectable subspecialty.

Published online February 12, 2020.

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Disclosures of financial or other potential conflicts of interest: None.

"Correctional facilities across the United States already struggle to provide adequate mental health services to incarcerated patients.

Rather than waiting for mass incarceration to disappear while incarcerated individuals experience widespread untreated mental illness, **mental health professionals can use their skills to heal patients with some of the greatest needs and to change the criminal justice system from within**."

Finding a Voice

Elizabeth Ford, M.D.

Long before COVID-19's death march and the continued killing and imprisonment of Black people by the criminal legal system emphasized the profound and unjust racial and health inequities that exist in the United States, I was entrenched in my own ethical turmoil.

After I had spent 20 years learning to be a psychiatrist for people in New York City with serious mental illness who were detained in the city's jails, including on Rikers Island, my physical and emotional health was suffering. I knew that I needed to leave the hospital and jail institutions with which I had become so familiar, but I was afraid. Afraid to leave the traumatized professional family with whom I had formed such close bonds. Afraid to step into a new role where I would be tested and judged. Afraid that the dehumanizing and cruel behaviors I witnessed were not limited just to captivity. I had heard too many patients in jail talk about "outside," where the risk of being raped in a shelter on a Code Blue winter night or being kicked out of an emergency room by angry doctors was worse than incarceration.

My journey began while I was working in, and eventually leading, one of the most historically notorious psychiatric units in the country: the Bellevue Hospital Psychiatric Prison Ward. It is there where patients from the jails go when they are too dangerous for jail. Decisions about access to these coveted inpatient beds are based on the laws of New York State (1, 2) that empower doctors to subjectively diagnose mental illness on the basis of a manual (3) whose field trials do not include the Black and Brown, impoverished, incarcerated patients I was trying to treat. Highly stigmatized diagnostic labels such as "malingerer" and "personality disorder" were too quickly applied to traumatized patients by psychiatrists and psychologists who had little idea of the true impact of confinement. My work there focused on feeling and showing respect for the patients for whom we cared and encouraging others to do the same.

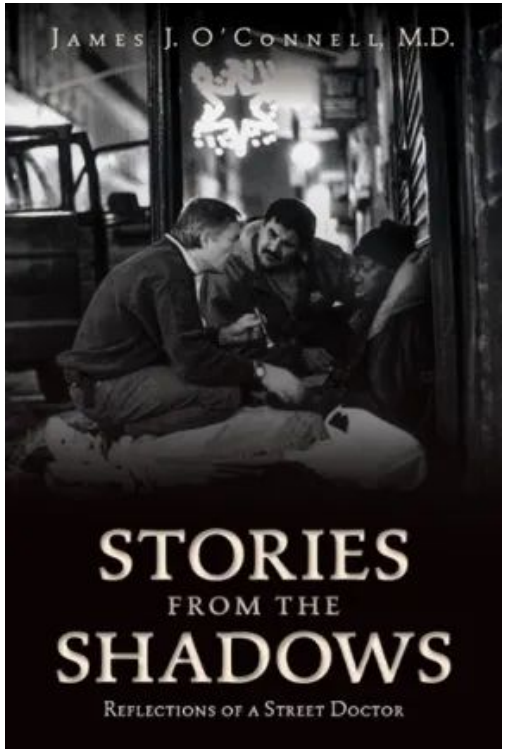
Measurable improvements had been made by the time I left (4), but after almost a decade at Bellevue, I could no longer bear the near-suicides and patients with fractured bones coming in from Rikers. I was sure that on that island was the root cause of the trauma and learned helplessness among my patients that no treatment in the hospital seemed able to cure. Therefore, I jumped into the jail's health care system as chief of psychiatry to find and try to mend some of those deep wounds.

During my years there, I witnessed such cruelty and neglect that I was at times driven to cursing and tears in front of men with gold stars, and I sought treatment for my own posttraumatic stress disorder (PTSD). I found examples of the insidious and profound effects of law-and-order policies, approved by an uninformed or indifferent public, on human beings in confinement. Social workers struggled to keep up with the relentless admission of people who were not dangerous, merely too poor to pay bail. Doctors buckled under the pressure of dual loyalty—the potential conflict between physicians' duty to their patients and the expectations of a confinement system—leading to a young man with progressive muscle weakness being repeatedly dismissed by both jail and hospital, only to be correctly diagnosed just days before requiring intubation. Officers without adequate training or support in the jail's suicidogenic environment watched as a man tied a T-shirt to an exposed pipe and then to his neck, hanging with his feet inches from the floor. Just as at Bellevue, my work was focused on respecting humanity and finding hope.

By the time I left Rikers Island, only 2 weeks before the first known cases of COVID-19 started appearing in the United States, there had been only one suicide in 4 years. New mental health units had been created that are now considered a national model of care. The practice of isolating unusually violent or self-injurious "problematic" people with serious mental illness in dark holding cells had stopped. A list of bright young psychiatrists and psychologists were eager to sign on to the mission. One Friday evening, I stopped at the doorway of a colleague's office to say a quick goodnight. She told me about a young man with intellectual disability who was thriving in one of the new jail mental health units. "He said that this is the nicest place he's ever been in his life," she told me, "and he doesn't want to leave."

Although I felt proud about being part of this progression toward benevolence, I could not help but wonder whether I was also causing harm. In working so hard to improve the quality of mental health treatment in the jails and in joining with a team of devoted doctors who take care of people no one else will, was I justifying the jail as a treatment facility?

"There need to be voices who scream from the inside, **who work to alleviate suffering in the spaces that cause suffering**, and who bear witness to the displays of human cruelty and neglect that institutions of confinement can create. Psychiatrists can and should represent more of those voices."



“As a resident at a major teaching hospital, I had witnessed how **doctors who care for excluded populations soon become marginalized by our own profession**. A career path in the care of poor and fragile populations was not viable within our academic medical centers and medical schools”

Contact Between Police and People With Mental Disorders: A Review of Rates

James D. Livingston, M.A., Ph.D.

Objective: There is widespread belief that people with mental disorders are overrepresented in police encounters. The prevalence of such interactions is used as evidence of extensive problems in our health care and social support systems. The goal of this study was to estimate the rates of police arrests among people with mental disorders, police involvement in pathways to mental health care, and police calls for service involving persons with mental disorders.

Methods: A systematic review was performed with seven multidisciplinary databases. Additional studies were identified by reviewing the reference lists of all included records and by using the "related articles" and "cited articles" tools in the Web of Science database. Studies were included if they were published in peer-reviewed journals, reported primary research findings, and were written in English.

Results: Eighty-five unique studies covering 329,461 cases met inclusion criteria. Data reported in 21 studies indicated that one in four people with mental disorders have histories of police arrest. Data from 48 studies indicated that about one in ten individuals have police involved in their pathway to mental health care. Data reported in 13 studies indicated that one in 100 police dispatches and encounters involve people with mental disorders.

Conclusions: These estimates illuminate the magnitude of the issue and supply an empirically based reference point to scholars and practitioners in this area. The findings are useful for understanding how local trends regarding police involvement in the lives of people with mental disorders compare with rates in the broader research literature.

Psychiatric Services 2016; 67:850–857; doi: 10.1176/appi.ps.201500312

Contemporary health care systems, social programs, and policing models have been designed in such a way that contact between people with mental disorders and the police is inevitable. Attending to mental health crises, working with witnesses and victims of crime, searching for those who have absconded from inpatient and residential care, and identifying people who have mental health needs and connecting them to services are the foreseeable duties for today's police officer (1,2). In addition, officers are called on to intervene in criminal acts—from public disturbances to more serious incidents involving threatened or actual violence—perpetrated by people exhibiting a variety of mental health problems, such as dementia, intoxication, intellectual disability, or serious mental illnesses (3).

To many police, interacting on a routine basis with people who have mental disorders is problematic (2). Police chiefs have asserted that officers should not be the mental health response agency of first resort and that mental health situations consume too much time of frontline officers, diverting precious resources from core law enforcement activities (4). For example, police officers routinely express concern about the amount of time spent waiting in hospital emergency rooms in combination with the prospect that individuals with mental disorders may not be admitted to inpatient care (1). Research has shown that contacts involving people with mental disorders place great demands on police resources (5). Police officers express frustration with deficiencies in the health and social service systems that severely constrain their ability to resolve situations involving people with mental disorders in a timely and appropriate manner. Serious concerns have also been raised by people with mental disorders about police interventions, particularly those that involve the use of force (6,7).

Media and academic discourses suggest that these encounters are a common and growing phenomenon, or "crisis" (8), but how truly common are these interactions? Although published reviews have examined the prevalence of mental disorders in various criminal justice populations and settings, such as correctional institutions (9,10), there has been no synthesis of rates within the context of policing. This study took stock of general trends within the extant knowledge by examining the rates of interaction between police and people with mental disorders. Published data on the following three rates were synthesized: police arrests among people with mental disorders, police involvement in pathways to mental health care, and police calls for service involving persons with mental disorders.

METHODS

A systematic search was conducted in PubMed, PsycINFO, Web of Science, JSTOR, Criminal Justice Abstracts,

"Overall, the findings suggest that **typically one in four people with mental disorders have histories of police arrest**"

Community Ment Health J (2012) 48:756–760
DOI 10.1007/s10597-012-9512-3

BRIEF REPORT

Can We Address the Shortage of Psychiatrists in the Correctional Setting with Exposure During Residency Training?

Brian S. Fuehrlein · Manish K. Jha · Adam M. Brenner · Carol S. North

Received: 1 September 2011 / Accepted: 11 March 2012 / Published online: 24 March 2012

Abstract Psychiatry residents at the University of Texas Southwestern Medical Center were surveyed to investigate their attitudes towards inmates, towards various aspects of correctional psychiatry and whether rotating at the local jail is associated with these attitudes. The overall opinion towards correctional psychiatry was fairly neutral though significantly more negative than towards inpatient psychiatry. While citing a high need for psychiatrists at correctional facilities, residents reported they are not likely to work there when they complete residency. No statistical differences were found between those residents who had rotated at the local jail and those who had not. Given the severe shortage of mental health providers in correctional facilities it is important to expose residents to this and understand ways to promote correctional psychiatry as a career.

completion of their sentences despite concerns that "the release of prisoners in large numbers is a matter of undoubted, grave concern" (Supreme Court p. 2). The primary reasons for the release included constitutional violations in the form of severe overcrowding as well as the severe shortage of mental and medical health care. Examples included prisoners not receiving even minimal care and suicidal inmates being held in telephone-booth sized cells for prolonged periods of time. Wait times for mental health care have been as long as 12 months, and 72 % of suicides involved some measure of inadequate assessment, treatment or intervention and were deemed foreseeable and preventable (Supreme Court 2011).

Although the above Supreme Court ruling provides a specific example, the need for mental health care in jails and prisons is a national phenomenon. Every 5–6 years

September 2017, Volume 19, Number 9: 913-921

MEDICAL EDUCATION

Medicine and Mass Incarceration: Education and Advocacy in the New York City Jail System

Jonathan Giftos, MD, Andreas Mitchell, and Ross MacDonald, MD

Abstract
The United States incarcerates more people than any other country in the world. The scale of mass incarceration ensures that almost all practicing physicians will treat formerly incarcerated patients. Yet the majority of physicians receive little training on this topic. In this paper, we will outline the need for expanded education on the interface between incarceration and health, describe initiatives taking place within the New York City jail system and nationally, and describe future directions for curriculum development. We conclude by highlighting the important role health care workers can play in transforming our criminal justice system and ending mass incarceration.

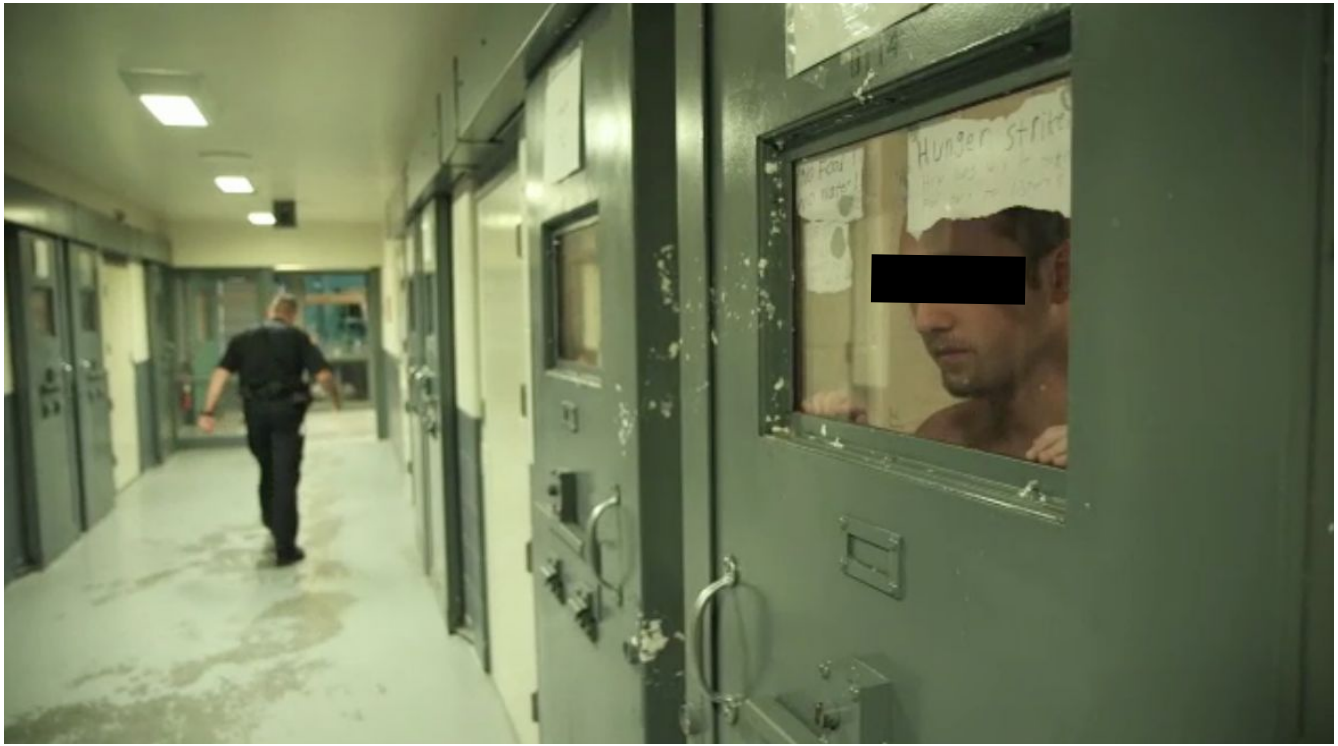
Introduction

The United States incarcerates more people than any other country in the world [1], with 10.9 million people passing through its jails [2] and an estimated 6.7 million under correctional supervision in 2015 [3]. The scale of this mass incarceration—historically high rates of imprisonment, especially among young men of color [4]—along with the fact that the vast majority of incarcerated patients will return to their communities, ensures that almost all practicing physicians will treat justice-involved patients [5]. While innovators like the Transitions Clinic Network [6] have modeled comprehensive care for patients with a history of incarceration, most returning citizens will find themselves in a health care system that might not appreciate the harms of incarceration or the challenges of reentry.

Furthermore, incarcerated patients are disproportionately burdened by chronic medical problems and are exposed to health risks inherent to incarceration itself. Substance use disorders and severe mental illness are especially common [7, 8], and even short jail incarcerations can confer new morbidity due to violence, forced detoxification, medication interruption, and worsening mental health or self-harm during solitary confinement [9].

While *Estelle v Gamble* established the legal right to health care for incarcerated patients in 1976 [10], this right has not guaranteed access to clinicians with the knowledge,

The New Asylums / PBS



Last Days of Solitary / PBS

Taking Legal Histories in Psychiatric Assessments

Nathaniel P. Morris, M.D.

People with mental illness are often disproportionately affected by the U.S. justice system, yet psychiatrists and other mental health professionals may avoid or feel uncomfortable talking with patients about legal history. This column examines why legal history is relevant to psychiatric assessments and provides guidance for talking with patients about these issues. Key aspects of taking a legal history are reviewed, including suggested questions, the role of collateral information, and considerations for medicolegal documentation. Developing skills in taking patients' legal histories may equip clinicians to better understand their patients' stories and to provide more effective psychiatric care.

Psychiatric Services 2018; 69:748–750; doi: 10.1176/appi.ps.201800183

The American legal system shapes the lives of many people living with mental illness in this country. Researchers have estimated that at least 10%–25% of inmates in U.S. jails and prisons have some form of mental illness (1,2). Jails and prisons are now believed to house approximately 10 times as many people with serious mental illness as all remaining state mental hospitals (2). Studies suggest that one in four people with mental illness has a history of police arrest (3) and that inmates often have higher rates of mental health issues than the general population (4,5). These associations are not limited to adults; youths in the juvenile justice system also appear to have high rates of mental illness (6).

Patients who present for psychiatric evaluation may have legal histories that are pertinent to their care. How frequently clinicians assess patients' legal histories remains poorly studied, but evidence suggests that many mental health professionals avoid forensic issues in clinical practice. There are marked shortages of mental health professionals in correctional settings (7), and trainees often do not participate in clinical rotations at correctional facilities (8–10). A survey of psychology graduate students published in 2007 found that over 30% did not "want forensic/correctional training" (10). A 2012 survey of Texas psychiatry residents found trainees harbored more negative attitudes toward inmates compared with other patients and would rather not work in correctional settings (8).

Mental health professionals may not always learn about the importance of evaluating patients' legal histories. For example, while the Accreditation Council for Graduate Medical Education requires that psychiatry residents demonstrate knowledge in the "legal aspects of psychiatric practice" (11), residents are not required to demonstrate competency in taking a patient's legal history before becoming practicing psychiatrists. Guides to psychiatric assessments frequently omit or give cursory attention to the role of legal history in the clinical evaluation. Trainees may assume that they should ask about legal history only with certain patients (e.g., those with past violence or antisocial traits).

Still, the mass incarceration of Americans with mental illness demands that mental health professionals pay attention to patients' legal histories. This column reviews why mental health professionals should assess patients' legal histories and how to approach this potentially sensitive subject with patients.

Relevance to Psychiatric Assessments

Legal history can influence psychiatric treatment decisions. The nature of a patient's legal history (e.g., a remote traffic infraction versus recurrent incarceration for violent crimes) can help to refine diagnostic impressions. Patients may have encountered psychotherapy, psychotropic medications, or other elements of psychiatric care in correctional settings, which can shape patients' attitudes toward such services. Major developments in a patient's psychiatric history, such as first-episode psychosis or self-harm, may have occurred during incarceration. Beyond the criminal justice system, many patients face civil cases or legal aspects of mental health care, such as involuntary hospitalization or conservatorship, knowledge of which may inform clinical decision making.

Taking a legal history can help mental health professionals fulfill two of their most vital functions—assessing suicide risk and violence risk. Incarceration can place individuals at high risk of suicide (12), and patients may have harmed themselves or attempted suicide under custody in the past. Similarly, prior legal history, including convictions for violent crimes, restraining orders, and weapons-related charges, can be key in assessing a patient's propensity for violence. Ongoing legal issues can be psychosocial stressors that elevate a patient's risk of suicide or violence. Ignoring a patient's legal history may lead clinicians to formulate grossly inaccurate clinical assessments of patients' dangerousness to themselves or others.

Patients with legal histories may suffer from worse health outcomes compared with those without prior legal troubles (13,14). People with histories of incarceration are particularly

"Understanding the experience of mental illness in the United States can be difficult without **talking with patients about their interactions with the legal system**"

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., *Editor*

Reconstructive Justice — Public Health Policy to End Mass Incarceration

Eric Reinhart, M.D.

In 1994, at 26 years of age, Dennis Wayne Hope was placed in solitary confinement in a Texas prison after he had escaped and remained free for 2 months. Until he was recently hospitalized, he had been confined to a dark cell not much bigger than a king-size mattress for the past 27 years. In that time, he had been permitted one personal phone call — in 2013, after his mother died — and had seen virtually no one other than the guards who strip-searched him whenever he was taken, handcuffed, to another room to exercise by himself. According to court documents, he now faces severe depression, paranoid auditory and visual hallucinations, and suicidality. He has written to his lawyers that he fears he may be losing his mind.[1]

After an appeals court ruled against Hope's petition to impose limits on solitary confinement as a violation of the Eighth Amendment prohibition on cruel and unusual punishment, the U.S. Supreme Court may soon decide whether the quarter-century he has spent subjected to what the United Nations defines as torture merits their attention.[2,3] If the justices hear his case, it will require remarkable callousness to refuse to acknowledge the cruelty involved in Hope's treatment, but the Court will be hard pressed to characterize prolonged subjection to solitary confinement as "unusual" in America.

During ordinary times in the United States, approximately 80,000 people are held in solitary confinement, and more than 10% of them have spent 3 years or more under these conditions.[4] Solitary confinement has for decades been so routinized that a recent study, for example, showed that 13% of all Black men in Pennsylvania born between 1986 and 1989 had been held in solitary confinement by 32 years of age.[5] Nearly all of them endured these conditions for a period of more than 15 days — the threshold beyond which well-established international standards characterize solitary confinement as a violation of human rights.[3]

During the Covid-19 pandemic, jail and prison administrators have dramatically increased the number of people held in solitary, which had risen to approximately 300,000 by the summer of 2020.[6] As Covid-19 outbreaks continue, solitary is still being widely used as a "protective" measure. Over the first 2 years of the pandemic, expanded use of solitary was the default infection-control strategy to which officials turned in order to avoid complying with calls for mass decarceration, which was recommended by health and safety experts as the best way to keep incarcerated people safe and to stop jails and prisons from amplifying the pandemic and spreading deadly disease throughout surrounding communities.[7,8] This policy has not only failed to prevent carceral Covid-19 outbreaks — it has also generated a shadow epidemic of psychological and physiological injury that will reverberate for decades to come.

THE AFTERLIVES OF ABUSE BEHIND BARS

For people subjected to torture, the harm doesn't end when the torture technically ends. It haunts them — in both body and mind — for entire lifetimes. It also haunts their children, parents, partners, families, communities, and countries. It affects their ability to maintain relationships, sleep, make sense of their environments, trust others, hold jobs, make meaning and pleasure in life, and often simply to perform the basic tasks of bodily self-care.

When society inflicts severe injury on its

San Francisco Chronicle

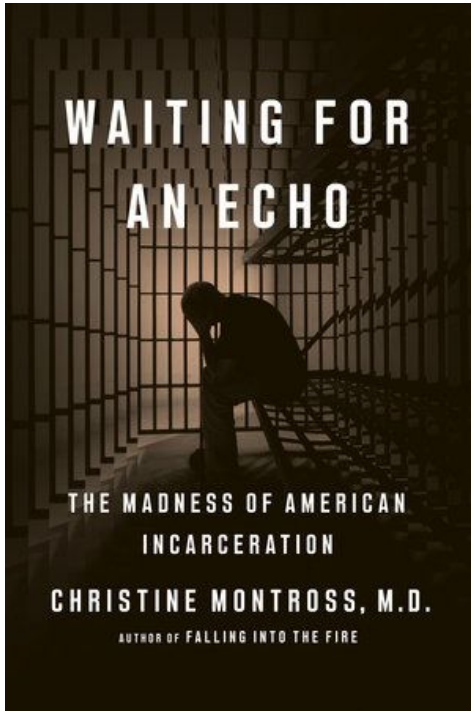
OPINION // OPEN FORUM

Help mentally ill with police training and treatment, not jail

Matthew E. Hirschtritt and Renee L. Binder

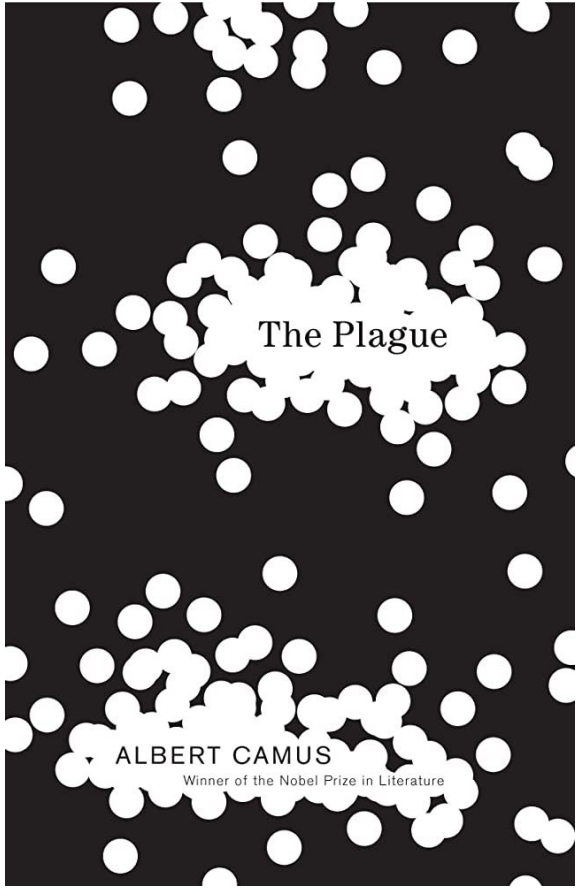
Updated: March 9, 2017 8:30 p.m.

Interim police chief Tony Chaplin held a press conference releasing footage from SFPD officers Kenneth Cha and Colin Patino during their altercation with 42 year old Sean Moore earlier this month released on Wednesday, January 18, 2017, in San Francisco, Calif.
Liz Hafalia/The Chronicle

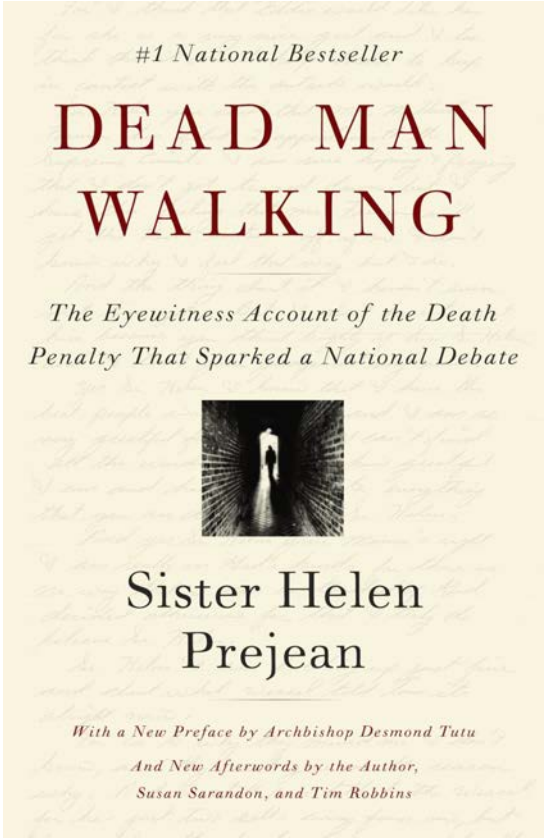


Outline

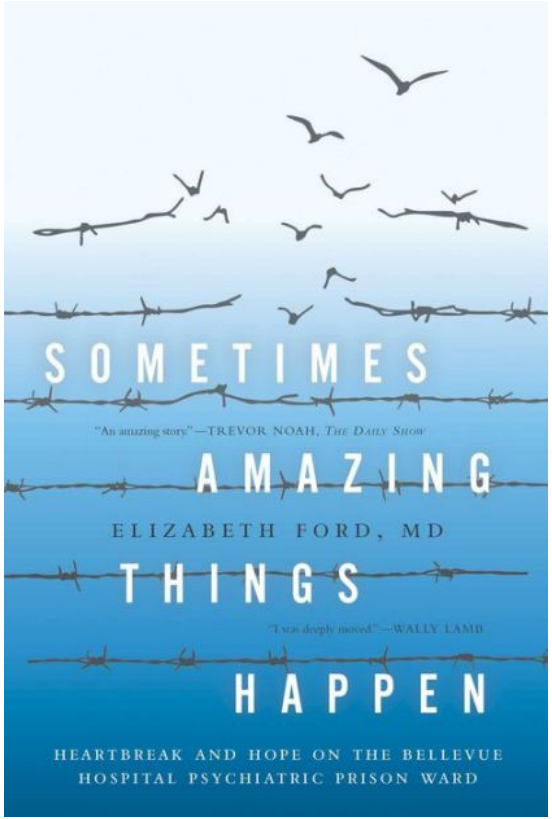
1. Mass Incarceration in the United States
2. Incarceration and Mental Illness
3. Mental Health Care in Jails and Prisons
4. Rethinking Incarceration as a Front Line of Mental Health Care
5. **Closing Thoughts**



“For though some prisoners are kept solitary, a prison forms a sort of community, as is proved by the fact that in our town jail **the guards died of plague in the same proportion as the prisoners.** The plague was no respecter of persons and under its despotic rule **everyone, from the warden down to the humblest delinquent, was under sentence** and, perhaps for the first time, impartial justice reigned in the prison.”



“It would take me a long time to understand how systems inflict pain and hardship in people’s lives and to learn that **being kind in an unjust system is not enough**”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"I was deeply moved."—WALLY LAMB
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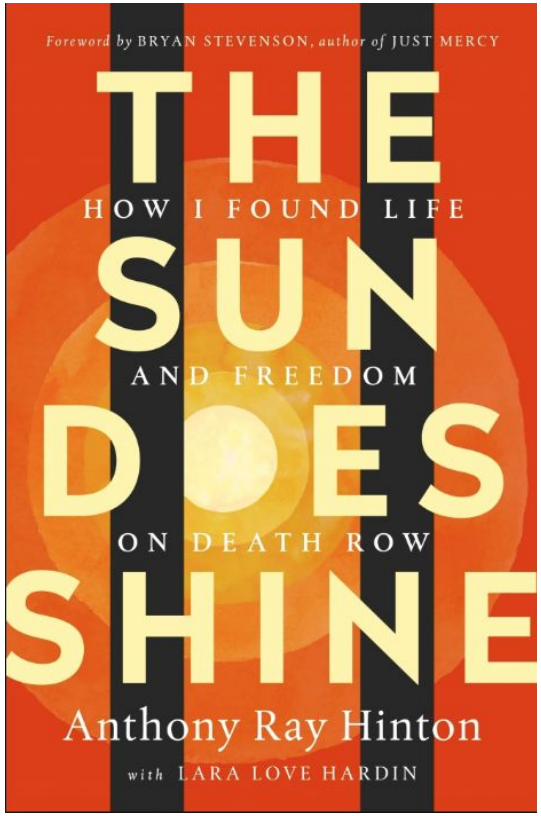
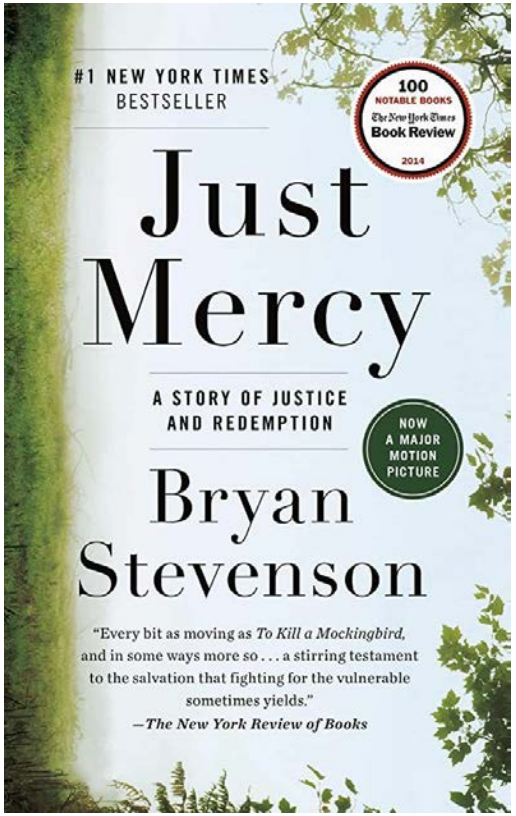

Foreword by BRYAN STEVENSON, author of JUST MERCY
THE SUN DOES SHINE
HOW I FOUND LIFE
AND FREEDOM
ON DEATH ROW
Anthony Ray Hinton
with LARA LOVE HARDIN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