Ethical Dilemmas in Providing Mental Health Care Behind Bars

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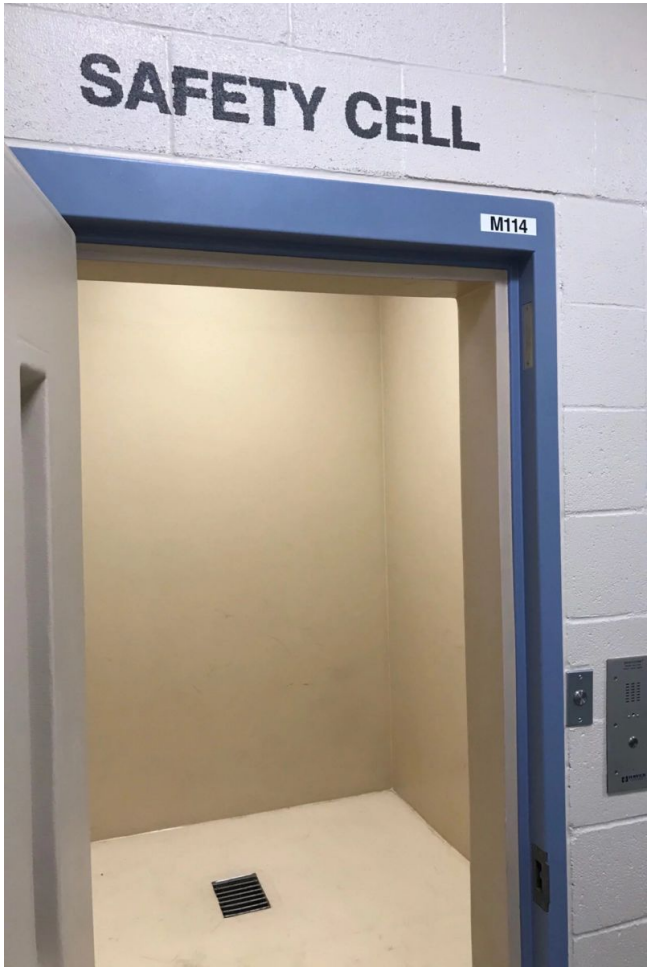
Disclosures

- 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

Last Days of Solitary / PBS

John McCoy / Los Angeles Daily News



Jason Pohl/Sacramento Bee

So…

So…

...how do you work
in a place like this?

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. Mental Health Professionals Should Work in Jails and Prisons
4. Paths Forward
5. Conclusions

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    a. **“Criminals” Do Not Deserve Health Care**
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EDITORIAL

Care of the Mentally Ill in Prisons: Challenges and Solutions

Anasseril E. Daniel, MD

J Am Acad Psychiatry Law 35:406–10, 2007

So, where did all the [state hospital] patients go?—Emanuel Tanay, MD[1]

Jails and prisons have become the mental asylums of the 21st Century—CNN[2]

The United States has the highest rate of adult incarceration among the developed countries, with 2.2 million currently in jails and prisons. Those with mental disorders have been increasingly incarcerated during the past three decades, probably as a result of the deinstitutionalization of the state mental health system. Correctional institutions have become the *de facto* state hospitals, and there are more seriously and persistently mentally ill in prisons than in all state hospitals in the United States.

A systematic review of 62 surveys of the incarcerated population from 12 Western countries[3] showed that, among the men, 3.7 percent had psychotic illness, 10 percent major depression, and 65 percent a personality disorder, including 47 percent with antisocial personality disorder. Among the women, 4 percent had psychosis, 12 percent major depression, and 42 percent a personality disorder. In addition, a significant number suffered from anxiety disorders, including post-traumatic stress disorder (PTSD), organic disorders, short- and long-term sequelae of traumatic brain injury (TBI), suicidal behaviors, distress associated with all forms of abuse, attention deficit hyperactivity disorder (ADHD), and other developmental disorders, including mental retardation and Asperger's syndrome. Most of the incarcerated were economically disadvantaged and poorly educated with inadequate or no vocational and employment skills. Approximately 70 percent had primary or comorbid substance abuse disorders.

Owing to the lack of widespread utilization of diversion programs such as mental health and drug courts at the front end of the criminal justice process, more people with these morbidities are entering prisons than ever before. At the back end, about 50 percent reenter prisons within three years of release (a phenomenon known as recycling), because of inadequate treatment and rehabilitation in the community. Systematic programs linking released mentally ill offenders to state mental health programs are few and far between. The immediate post-release period is particularly risky for suicide and other causes of death.[4]

A recent study (2006) by the U.S. Department of Justice[5] found that more than half of all prison and jail inmates have a mental health problem compared with 11 percent of the general population, yet only one in three prison inmates and one in six jail inmates receive any form of mental health treatment.

Questions

Are our prisons' rehabilitative services set up to provide comprehensive mental health and psychiatric programs to deal with the increasing population with such severe psychopathology and impairment? Shouldn't standards of care of psychiatric disorders be respected in the correctional setting as they are in other community provider settings? Shouldn't in-

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"Compared with the public, offenders may seem less cooperative, less appealing, and **even less 'human'"**

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Debunking the Myths of American Corrections: An Exploratory Analysis

Jeffrey Ian Ross

Published online: 15 May 2012

Abstract This article briefly reviews the literature on the myths of corrections and then identifies sixteen of the most prominent misrepresentations about jails, prisons, correctional workers, and convicts in the United States. It then systematically examines the reality of each. The article uses scholarly research, governmental and news reports, and personal experience of former inmates to cast doubt on many of the myths that have been developed. It argues that most of the misrepresentations about corrections can be called into question.

Introduction

Myths are statements or stories that embellish the truth. They are passed on from person to person, organizations to their members, and sometimes from generation to generation. Myths are often accepted without much regard to (or knowledge about) the evidence that challenges them. We have myths about all sorts of individuals, organizations, professions, places, processes and experiences. Myths have deep roots in folklore and culture and are often timeless.

Despite advances in both the physical and social sciences, numerous people, places and things are shrouded in myths, misconceptions, misrepresentations, and misinformation. Myths serve numerous purposes including disguising the original intent of the person or constituency who made the original communication, filling gaps in our knowledge, and convincing the public of the virtues of the mythmaker (Kappeler and Potter 2005; Bohm and Walker 2006). Perhaps nowhere is the presence of myths more noticeable than in the American criminal justice system (Pepinsky and Jesilow 1985). All branches, from the courts to law enforcement agencies, to the individuals who work and/or are monitored and processed by the criminal justice system have fallen prey to the problem of myths. Although these myths are occasionally challenged, rarely are the myths about corrections

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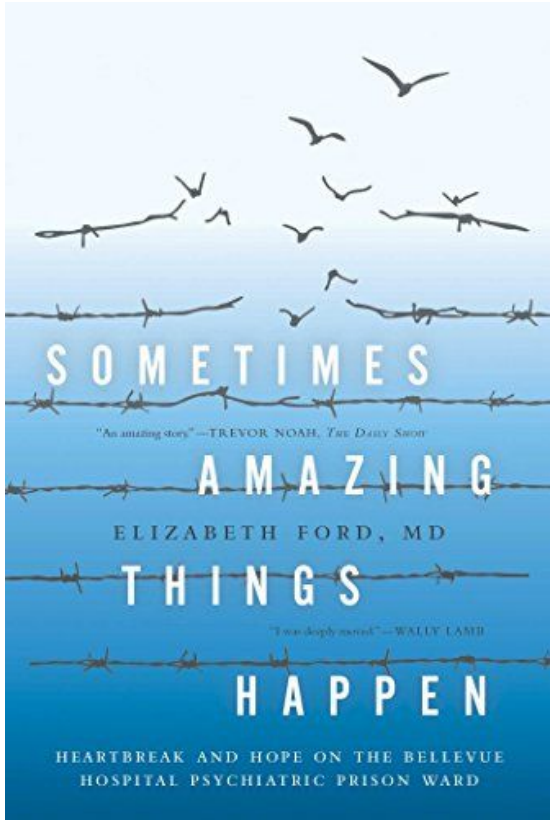
"Inmates are thought to be **given above average and completely free medical and dental care** that typically is denied to the less-well off in society"



“For most doctors, working behind bars with patients **whom others see as criminals, inmates, even “bodies,”** is not very appealing”

A PIECE OF MY MIND

Prisoner of My Preconceptions

Jason Chertoff, MD, MPH
Division of Pulmonary, Critical Care, and Sleep Medicine, Department of Internal Medicine, University of Florida College of Medicine, Gainesville.

It was an unusually tranquil day in our medical intensive care unit (MICU). Ventilator alarms were not blaring, intravenous drips were not urgently beeping, and vital sign monitors were not alerting us to any unstable patients. Certainly this calm could not last for long—and it didn't.

I soon overheard our charge nurse mention that a prisoner from a regional correctional facility was in the emergency department (ED) with "really bad sepsis."

"Ugh," I muttered in quiet annoyance. In my experience, these patients never fared well. Moreover, my cynical side suspected that more wasteful use of limited health care resources was on the horizon. Perhaps I would have felt differently if the patient were not a prisoner; I have no doubt a large part of my reaction was that part of me assumed that anyone who winds up in prison probably is a "bad person."

Four heavy-set grizzly men in tan security guard uniforms accompanied the cachectic prisoner into the MICU. I immediately noticed that he was shackled to the hospital bed by numerous cuffs and full-body restraints, all of which seemed unnecessary since he was heavily sedated, intubated, and mechanically ventilated. It seemed as though the excessive correctional paraphernalia were there simply to indicate the misguided and reckless life choices that he presumably chose. They may as well have written on his forehead, "I am deplorable."

I overheard the signing-off ED nurse say in a monotone voice, "the patient is a 53-year-old male inmate with diffuse large B-cell lymphoma being admitted for presumed septic shock from a necrotic right thigh mass."

"53? He looks more like 83," I thought in sheer disbelief. I considered what a grueling life this man must have led to look as feeble as he did.

Once the transfer was complete and the patient was settled in his room, it was obvious that his sepsis was due to a decaying, malodorous mass protruding from his lower extremity, along with a large left pneumonia and empyema. Standard sepsis bundles and protocols were initiated and the patient continued receiving a broad-spectrum of antibiotics, intravenous fluids, and two vasopressors. For source control, general surgery was consulted for debridement of his grossly infected, necrotic thigh mass, and he would require a chest tube to drain the empyema. I immediately cringed at the assuredly onerous process of obtaining informed consent for the invasive procedures. Consent could not be obtained directly from the patient for obvious reasons, and I was dubious that any family members would be reachable. Even if kin could be reached, I knew of the cumbersome hoops that I would need to surmount to obtain the obligatory consent. I had no time for this right now; the patient was now hemodynamically unstable and his respiratory status was deteriorating. I talked with an intern and asked him to tackle the dreaded consent quandary.

Ten minutes later, the intern said to me proudly, "Consents for the procedures are in the chart." I was flabbergasted and perplexed by the rapidity of the process. Little did I know that the patient was a married man with three children. Also unanticipated was that, despite being incarcerated, the patient was in fairly regular contact with family, which made for an effortless phone conversation between the family and intern, who easily and appropriately obtained consent.

As I sterilized and draped the patient in anticipation of his chest tube procedure, I was instantly jolted by compassion as I gazed into his lifeless eyes. I cannot attribute this emotional reaction to any specific event, other than a fortunate revelation. To me, he was suddenly no longer a prisoner; he was a human being who had a wife and children who cared for him. Indeed, he likely made unsound decisions in the past, but right at that moment he did not resemble a convict, but instead a vulnerable person who was gravely ill. It is rare to have such an indelible emotional connection with a complete stranger, especially one whom my past prejudices would have precluded.

Like so many prisoners in our MICU, the patient ultimately succumbed to multiorgan failure from sepsis two days later. Although he died, this patient taught me two invaluable lessons that I anticipate will endure throughout my career. First, that my preconceptions of patients based on stereotypes are frequently erroneous. Second, and more importantly, that such stereotypes could stymie optimal patient care and opportunities for personal growth. Indeed, the episode highlighted to me in stark—and disturbing—relief that my passing assumptions about a patient's personal life and history could affect the effort I invest in cultivating an effective patient-physician relationship.

As I considered my experience with the patient, I began to think more broadly about whether prisoners have disparate health care outcomes when compared with the normal civilian population. Not surprisingly, the incarcerated US population presents challenges to the health care system due to a large infectious disease burden, chronic medical conditions, rising costs, and health disparities.[1-4]

Although prisoners and inmates make up less than 5% of the US population, they bear a disproportionate burden of infectious disease like tuberculosis, HIV/AIDS, hepatitis C, and countless others.[3] Moreover, prisoners and inmates are more likely to have chronic noninfectious illnesses like hypertension, asthma, arthritis, cancer, and hepatitis than the general US population.[3] The expanding and aging population of the correctional system is certainly driving increasing

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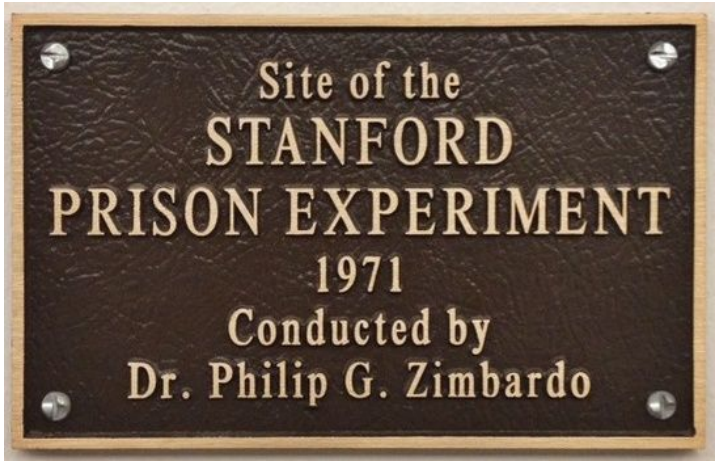
Moral Compromise



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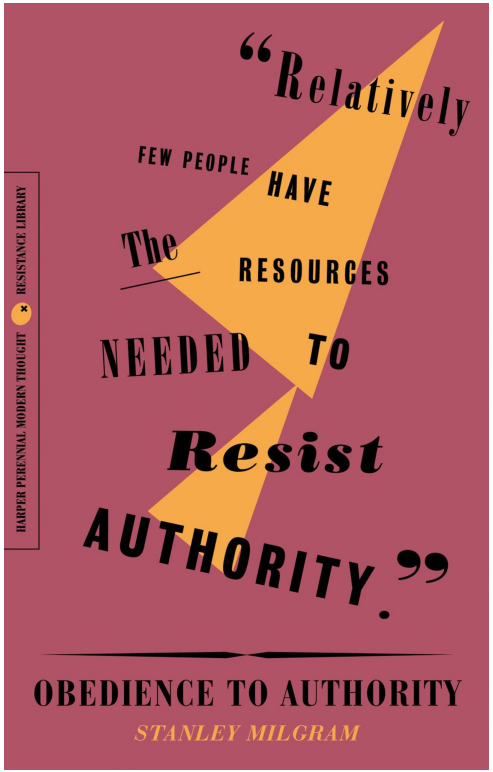
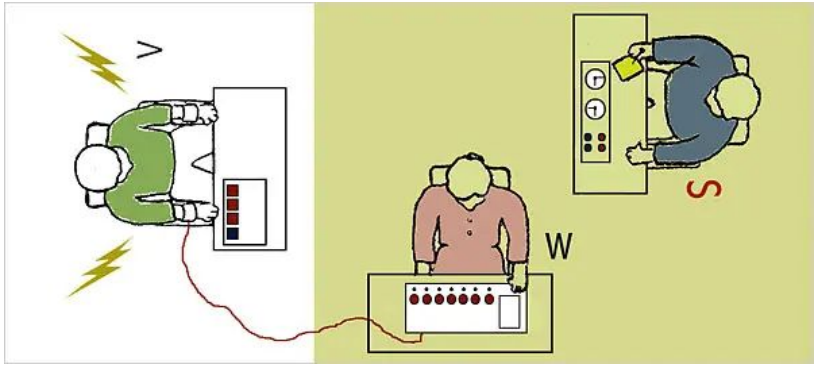
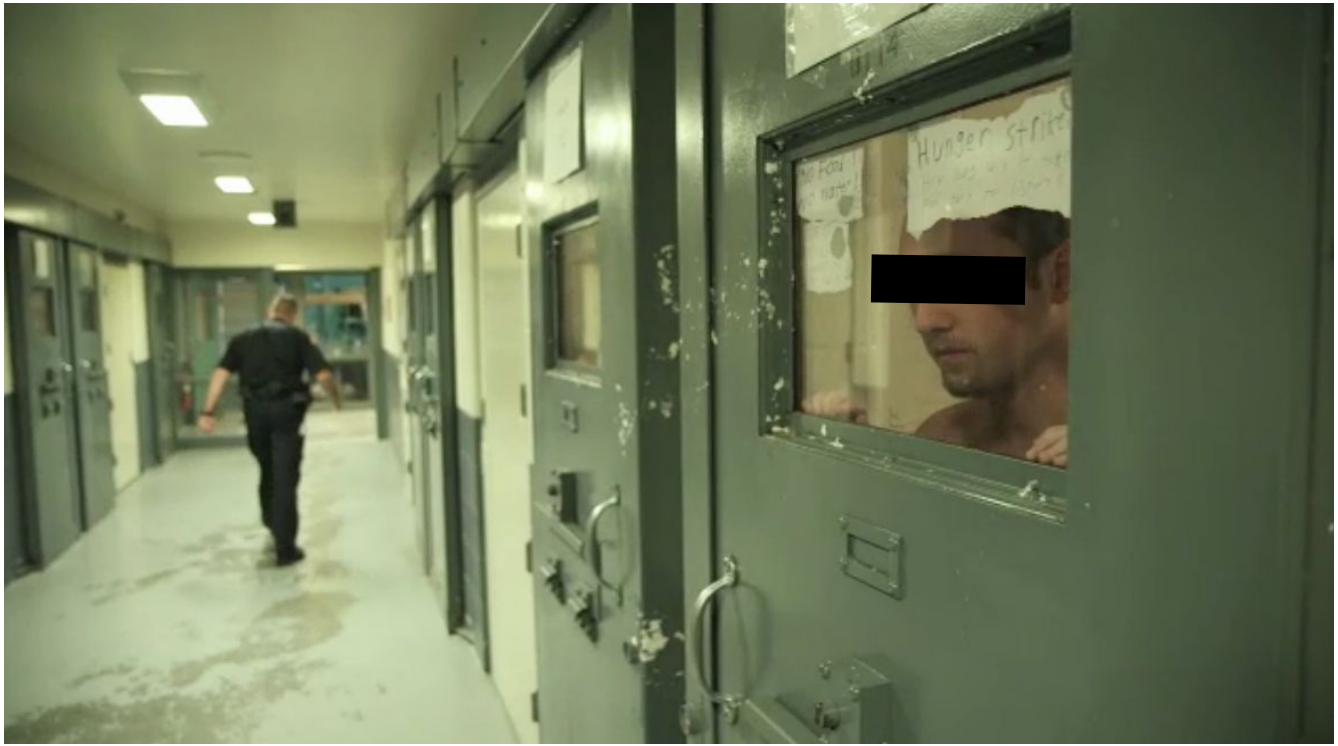




Alyson Fox / New York Times

Moral Compromise



Last Days of Solitary / PBS

Resolving Ethical Conflicts in Practice and Research

Dual Loyalty in Prison Health Care

Jörg Pont, MD, Heino Stöver, PhD, and Hans Wolff, MD, MPH

Despite the dissemination of principles of medical ethics in prisons, formulated and advocated by numerous international organizations, health care professionals in prisons all over the world continue to infringe these principles because of perceived or real dual loyalty to patients and prison authorities.

Health care professionals and nonmedical prison staff need greater awareness of and training in medical ethics and prisoner human rights. All parties should accept integration of prison health services with public health services.

Health care workers in prison should act exclusively as caregivers, and medical tasks required by the prosecution, court, or security system should be carried out by medical professionals not involved in the care of prisoners. (*Am J Public Health*. 2012;102:475–480. doi:10.2105/AJPH.2011.300374)

DUAL LOYALTY IS AN ETHICAL dilemma commonly encountered by health care professionals caring for persons in custody.[1,2] Dual loyalty may be defined as clinical role conflict between professional duties to a patient and obligations, express or implied, to the interests of a third party such as an employer, an insurer, or the state.[1] The dual loyalty practitioners most commonly face in prison is between their patients and the prison administration or the state authority.[1] We aim to shed light on the problem of dual loyalty in prison health care and to identify measures to reduce and solve the problem.

DOCUMENTS ON MEDICAL ETHICS IN PRISONS

Ethical rules for health care professionals in prisons are amply and clearly defined in rules, resolutions, declarations, and recommendations by the United Nations (UN),[3–6] the Council of Europe,[7–9] the World Medical Association,[10–14] the International Council of Nurses,[15] Physicians for Human Rights,[1] and Penal Reform International.[16] A few national codes also relate to health care matters in prison.[17–21]

According to these documents, the sole task of health care professionals working in prisons is the care of physical and mental health of the prisoners by

- acting as the private caregiver to the prisoners and observing the 7 essential principles of medical care in prison as quoted in the standards of the European Committee for Prevention of Torture (free access to medical care, equivalence of prison health care and community health care, confidentiality, patients' consent, preventive health care, humanitarian assistance, complete professional independence and competence)[9];
- advising the prison director on health affairs in prison, strictly obeying the 7 principles; and
- acting as a health and hygiene officer by inspecting and reporting on food, hygiene, sanitation, heating, lighting, ventilation, clothing, bedding, and physical exercise.

All of these tasks must be performed with complete loyalty to the prisoners; medical activities not in the interest of prisoners should not be undertaken by professionals who provide health care to prisoners, as stated clearly in principle 3 of the UN resolution on principles of medical ethics relevant to the role of health personnel in prison:

> It is a contravention of medical ethics for health personnel, particularly physicians, to be involved in any professional relationship with prisoners or detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.[3]

Such activities include forensic assessments, disclosure of patient-related medical data to others without consent of the patient, assisting in body searches or obtaining blood or urine for analyses for safety and security reasons, providing medical expertise for the application of disciplinary measures, and assisting or being complicit in physical or capital punishment, force-feeding, or torture.

The claim of exclusive concern with patients' welfare may strike some as excessive in light of the obligations health professionals have to third parties in other health care settings. However, health care professionals in prisons face extraordinary ethical challenges: prisoners, who cannot choose their care provider and who are fully dependent on the health care provided to them, are a vulnerable population, as demonstrated by the many exploitations, abuses, and violations of their human rights in the past.

"Dual loyalty is an **ethical dilemma commonly encountered** by health care professionals caring for persons in custody."

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Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail

SARAH GLOWA-KOLLISCH, JASMINE GRAVES, NATHANIEL DICKEY, ROSS MACDONALD, ZACHARY ROSNER, ANTHONY WATERS, HOMER VENTERS

Abstract

Dual loyalty is an omnipresent feature of correctional health. As part of a human rights quality improvement committee, and utilizing the unique advantage of a fully integrated electronic health record system, we undertook an assessment of dual loyalty in the New York City jail system. The evaluation revealed significant concerns about the extent to which the mental health service is involved in assessments that are part of the punishment process of the security apparatus. As a result, dual loyalty training was developed and delivered to all types of health staff in the jail system via anonymous survey. Six clinical scenarios were presented in this training and staff members were asked to indicate whether they had encountered similar circumstances and how they would respond. Staff responses to the survey raised concerns about the frequency with which they are pressured or asked to put aside their primary goal of patient care for the interests of the security mission. The online training and follow-up small group sessions have revealed widespread support for more training on dual loyalty.

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Competing interests: None declared.

"The sixth scenario presented the starkest and most threatening form of dual loyalty: **security staff members assaulting patients within the clinic.**"

"Almost 16% of respondents indicated that they had encountered or heard of this type of event."

British Journal of Clinical Psychology (2012)

The British Psychological Society
www.wileyonlinelibrary.com

The impact of prison staff responses on self-harming behaviours: Prisoners' perspectives

Lisa Marzano[1]*, Karen Ciclitira[2] and Joanna Adler[2]
[1]Department of Psychiatry, Centre for Suicide Research, Warneford Hospital, University of Oxford, UK
[2]Middlesex University, UK

Objectives. To further understanding of how health and correctional staff responses to self-harming behaviours influence prisoners and their subsequent actions.

Design. Participant-centred, qualitative methods were used to explore the complex and under-researched perspectives of self-harming male prisoners.

Method. Semi-structured interviews were conducted with 20 adult male prisoners who had engaged in repetitive, non-suicidal self-harm during their current prison sentence, or considered doing so. The interviews were analyzed drawing on principles of thematic analysis and discourse analysis.

Results. With some exceptions, prison officers, nurses, and doctors are portrayed by prisoners as being ill-prepared to deal with repetitive self-harm, often displaying actively hostile attitudes and behaviours.

Conclusions. These findings underscore the need for appropriate training, support and supervision for staff working with self-harming prisoners.

High rates of self-harming behaviour in clinical and institutional settings are a major concern in many countries, not least because individuals who self-harm are at increased risk of suicide (Owens, Horrocks, & House, 2002). Rates of self-harm in prisons have been repeatedly shown to surpass the rates recorded in the general population, both in the United Kingdom (Meltzer, Jenkins, Singleton, Charlton, & Yar, 1999) and elsewhere (Lohner & Konrad, 2006). In England and Wales, it has been estimated that up to 30% of prisoners have engaged in some form of self-harm during the course of their incarceration, mostly involving self-cutting (Brooker, Repper, Beverley, Ferriter, & Brewer, 2002). Addressing this issue is an important prison service (HM Prison Service, 2007) and public health priority (Department of Health, 2002).

It has long been argued that prisoner self-harm 'is not just a function of individuals' vulnerability and circumstances, but it is also influenced by the quality of prison regimes

*Correspondence should be addressed to Dr Lisa Marzano, Department of Psychiatry, Centre for Suicide Research, Warneford Hospital, University of Oxford, Oxford OX3 7JX (e-mail: lisa.marzano@psych.ox.ac.uk).

"In some instances, nurses and doctors were said to 'just patch you up' or 'just offer you medication', but **'don't believe you' and 'can't even give you a chance to talk with them'"**

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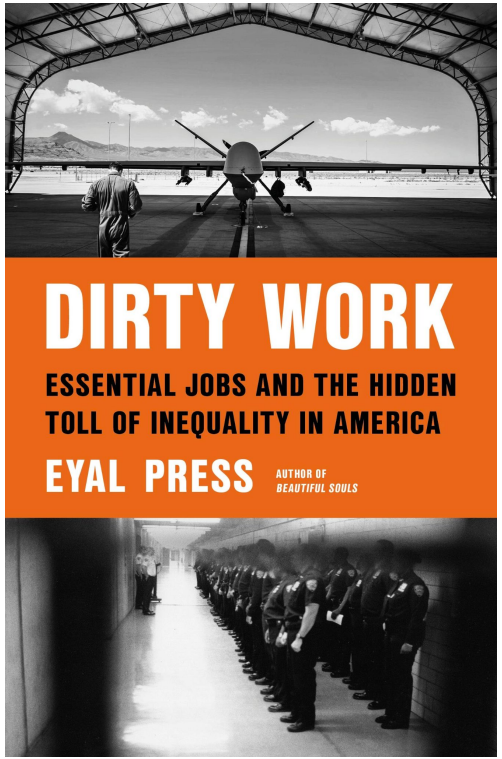
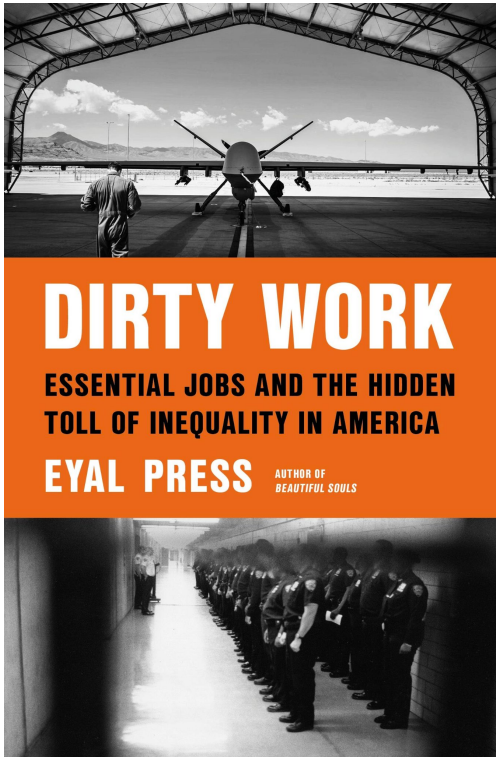
"The majority accused them of **not 'caring' and of responding in 'very rude' and 'judgemental' ways.** This included calling those who self-harm 'everything under the sun', patronizing them and **accusing them of 'seeking attention' and wasting staff time"**



"The nurses [explained] that he had been deliberately locked in the shower by guards, who directed a stream of scalding water at him…180 degrees, hot enough to brew a cup of tea. It would later be revealed that [he] had **burns on 90 percent of his body and that his skin fell off at the touch**"

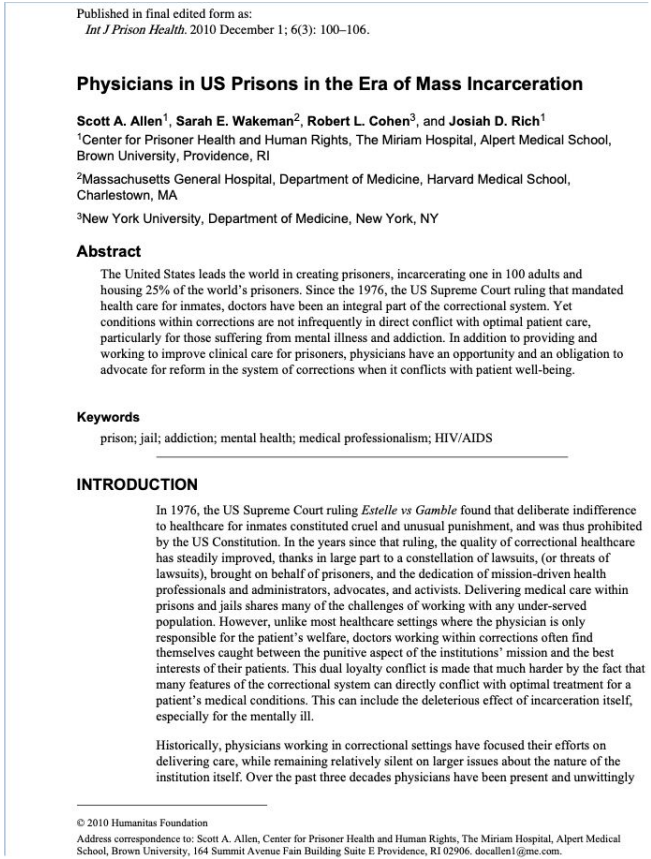


"As distraught as she was, **she did not file a report**…Neither did anyone else on the mental health staff…'it's not going to be me,' she said. One reason was her memory of the backlash she'd provoked for reporting something incredibly minor…Another was **her fear that any employee who became too vocal would end up getting fired**"

Outline

1. A Whispered Question
2. **Mental Health Professionals Should Not Work in Jails and Prisons**
    a. “Criminals” Do Not Deserve Health Care
    b. Moral Compromise
    c. Supporting Mass Incarceration
3. Mental Health Professionals Should Work in Jails and Prisons
4. Paths Forward
5. Conclusions

Supporting Mass Incarceration



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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]
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[2]Massachusetts General Hospital, Department of Medicine, Harvard Medical School, Charlestown, MA
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Abstract

The United States leads the world in creating prisoners, incarcerating one in 100 adults and housing 25% of the world's prisoners. Since the 1976, the US Supreme Court ruling that mandated health care for inmates, doctors have been an integral part of the correctional system. Yet conditions within corrections are not infrequently in direct conflict with optimal patient care, particularly for those suffering from mental illness and addiction. In addition to providing and working to improve clinical care for prisoners, physicians have an opportunity and an obligation to advocate for reform in the system of corrections when it conflicts with patient well-being.

Keywords

prison; jail; addiction; mental health; medical professionalism; HIV/AIDS

INTRODUCTION

In 1976, the US Supreme Court ruling *Estelle vs Gamble* found that deliberate indifference to healthcare for inmates constituted cruel and unusual punishment, and was thus prohibited by the US Constitution. In the years since that ruling, the quality of correctional healthcare has steadily improved, thanks in large part to a constellation of lawsuits, (or threats of lawsuits), brought on behalf of prisoners, and the dedication of mission-driven health professionals and administrators, advocates, and activists. Delivering medical care within prisons and jails shares many of the challenges of working with any under-served population. However, unlike most healthcare settings where the physician is only responsible for the patient's welfare, doctors working within corrections often find themselves caught between the punitive aspect of the institutions' mission and the best interests of their patients. This dual loyalty conflict is made that much harder by the fact that many features of the correctional system can directly conflict with optimal treatment for a patient's medical conditions. This can include the deleterious effect of incarceration itself, especially for the mentally ill.

Historically, physicians working in correctional settings have focused their efforts on delivering care, while remaining relatively silent on larger issues about the nature of the institution itself. Over the past three decades physicians have been present and unwittingly

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"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"

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?

"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?**"

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"In helping to write policies and to create practices that drastically reduced the suicide rate, was I legitimizing the jail's role in the prevention of death? **Was I actually helping to strengthen this institution** built by racism?"

HHR
Health and Human Rights Journal

Data-Driven Human Rights: Using Dual Loyalty Trainings to Promote the Care of Vulnerable Patients in Jail

SARAH GLOWA-KOLLISCH, JASMINE GRAVES, NATHANIEL DICKEY, ROSS MACDONALD, ZACHARY ROSNER, ANTHONY WATERS, HOMER VENTERS

Abstract

Dual loyalty is an omnipresent feature of correctional health. As part of a human rights quality improvement committee, and utilizing the unique advantage of a fully integrated electronic health record system, we undertook an assessment of dual loyalty in the New York City jail system. The evaluation revealed significant concerns about the extent to which the mental health service is involved in assessments that are part of the punishment process of the security apparatus. As a result, dual loyalty training was developed and delivered to all types of health staff in the jail system via anonymous survey. Six clinical scenarios were presented in this training and staff members were asked to indicate whether they had encountered similar circumstances and how they would respond. Staff responses to the survey raised concerns about the frequency with which they are pressured or asked to put aside their primary goal of patient care for the interests of the security mission. The online training and follow-up small group sessions have revealed widespread support for more training on dual loyalty.

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Nathaniel Dickey, MA, MPH, is the Special Assistant to the Assistant Commissioner of Correctional Health Services, Bureau of Correctional Health Services, New York City Department of Health and Mental Hygiene.

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Anthony Waters, PsyD, is the Director of Mental Health of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

Homer Venters, MD, MS, is the Assistant Commissioner of the Bureau of Correctional Health Services at the New York City Department of Health and Mental Hygiene.

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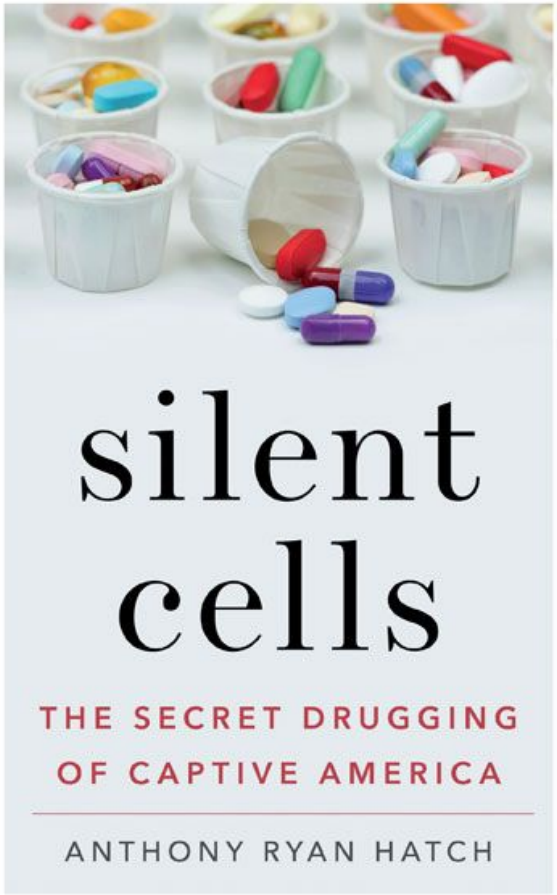
Competing interests: None declared.

"The most prominent example of dual loyalty is the **'clearance' of patients for punishment in solitary confinement**."

"In fact, many institutions employ health and mental health services **expressly to maintain the practice of solitary confinement**"



"In this book, I argue that psychotropics have become central not only to mass incarceration in prisons but also to other kinds of mass captivity within the U.S. carceral state."

"I address one big counterfactual question: ***Is it possible for the U.S. carceral state to exist without psychotropics?***"

Eric Risberg / AP

Kent Porter / Press Democrat

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. **Mental Health Professionals Should Work in Jails and Prisons**
4. Paths Forward
5. Conclusions

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. **Mental Health Professionals Should Work in Jails and Prisons**
    a. **Incarcerated People are People (With Tremendous Health Needs)**
4. Paths Forward
5. Conclusions

Incarcerated People are People

Karsten Moran / New York Times

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

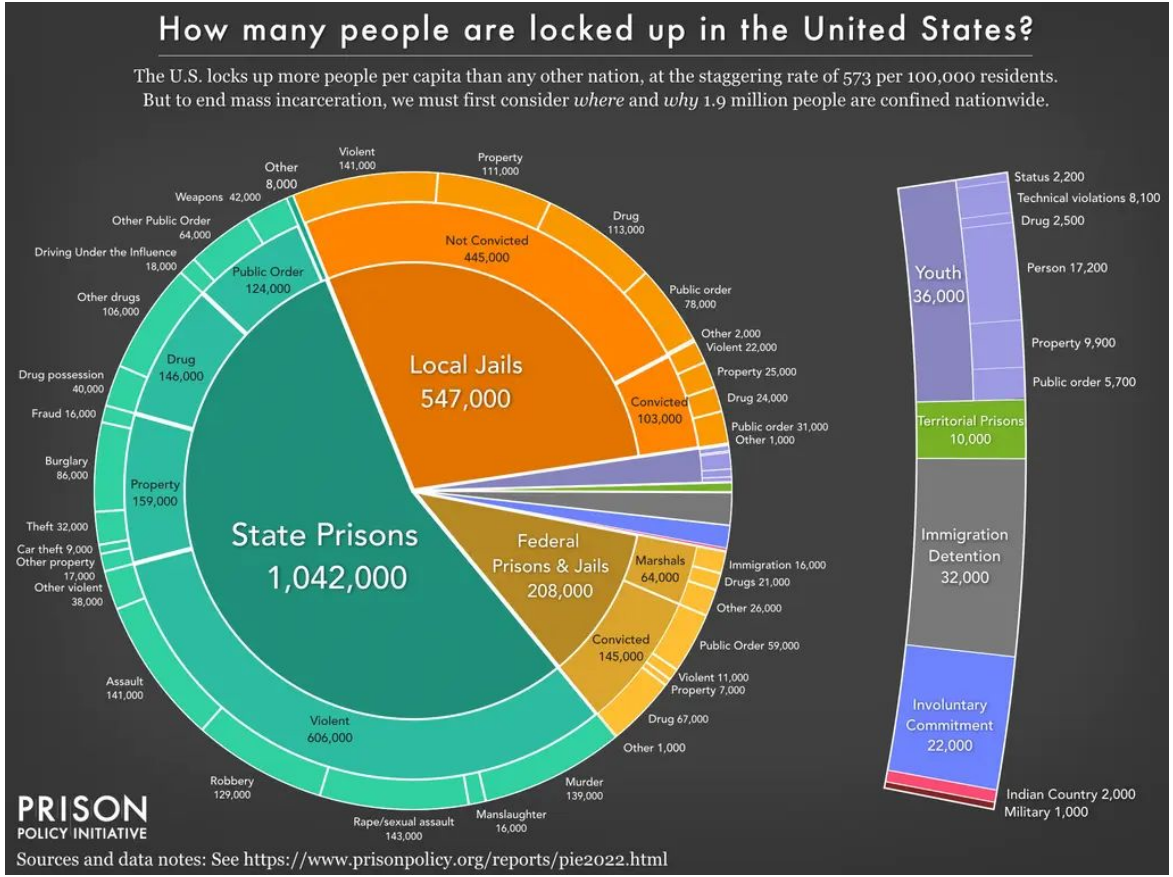
Peter K. Enns[1], Youngmin Yi[1], Megan Comfort[2], Alyssa W. Goldman[1], Hedwig Lee[3], Christopher Muller[4], Sara Wakefield[5], Emily A. Wang[6], and Christopher Wildeman[1,7]

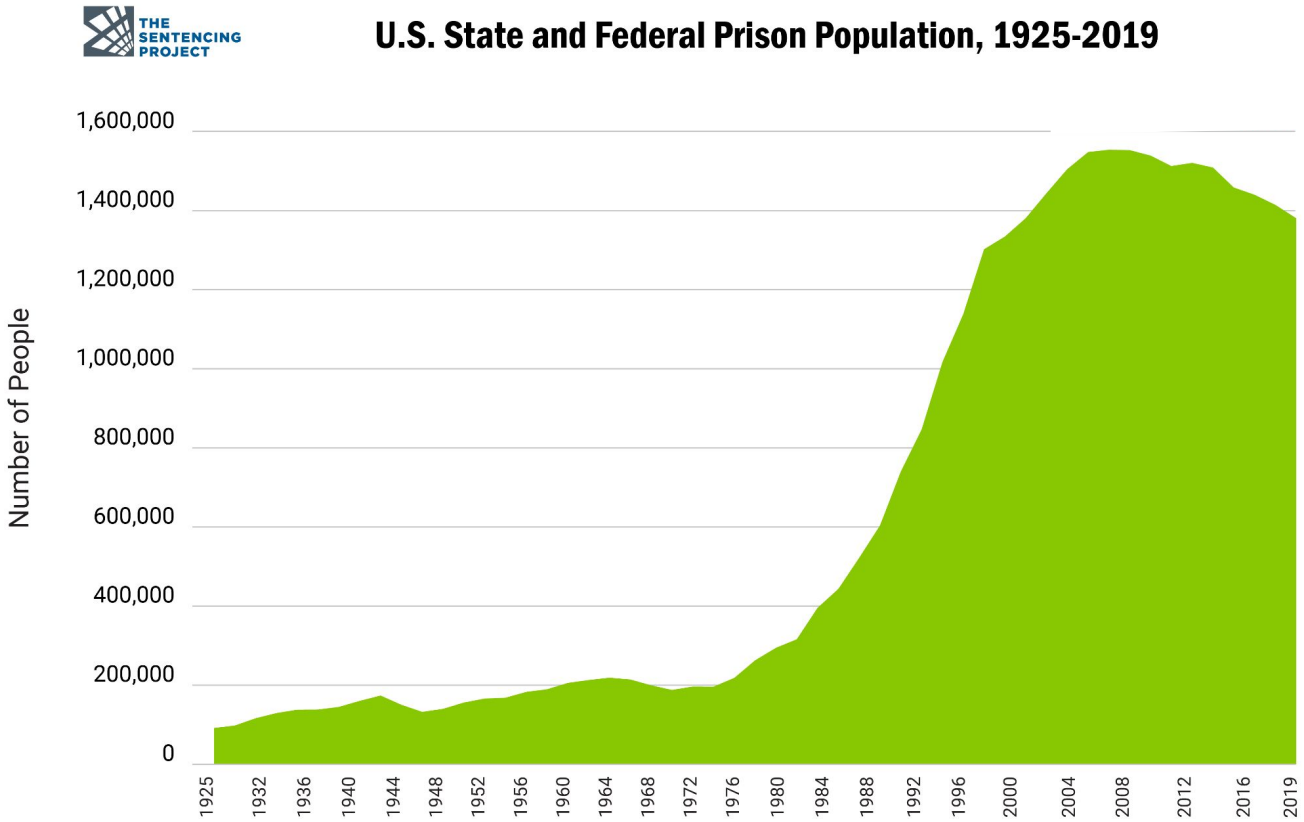
Socius: Sociological Research for a Dynamic World
Volume 5: 1–45

DOI: 10.1177/2378023119829332
srd.sagepub.com
SAGE

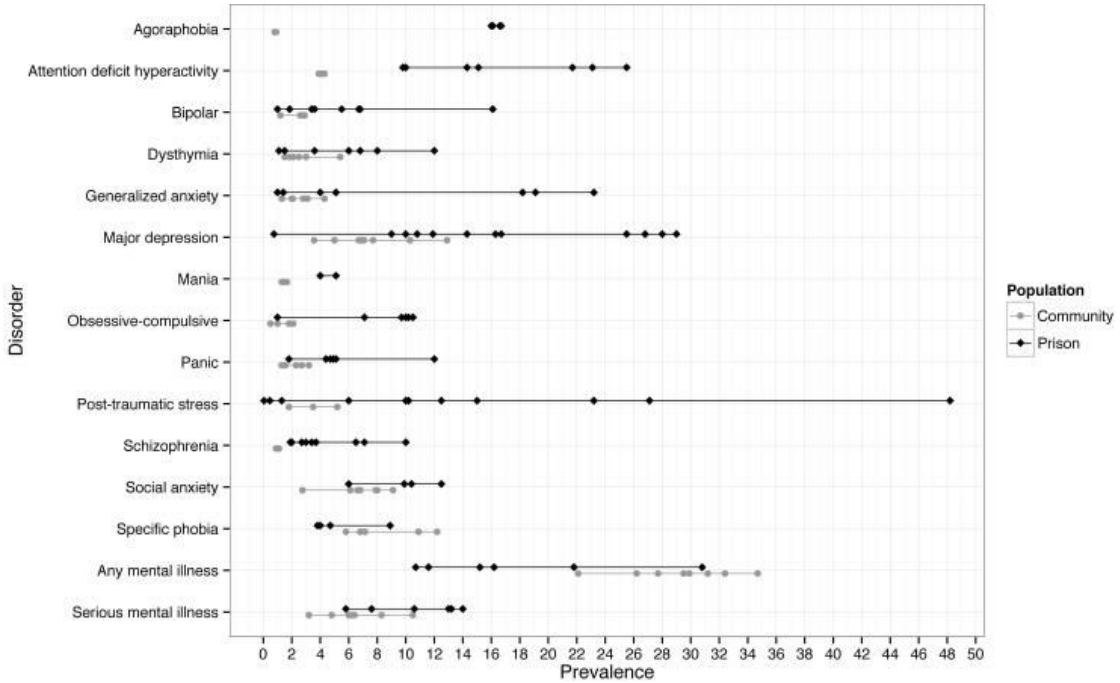
"The data show that **45 percent of Americans have ever had an immediate family member incarcerated**."

"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."


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 573 per 100,000 residents.
But to end mass incarceration, we must first consider *where* and *why* 1.9 million people are confined nationwide.
State Prisons 1,042,000
Local Jails 547,000
Not Convicted 445,000
Convicted 103,000
Federal Prisons & Jails 208,000
Marshals 64,000
Convicted 145,000
Violent 606,000
Property 159,000
Drug 146,000
Public Order 124,000
Violent 141,000
Property 111,000
Drug 113,000
Public order 78,000
Other 2,000
Violent 22,000
Property 25,000
Drug 24,000
Public order 31,000
Other 1,000
Immigration 16,000
Drugs 21,000
Other 26,000
Public Order 59,000
Violent 11,000
Property 7,000
Drug 67,000
Other 1,000
Murder 139,000
Manslaughter 16,000
Rape/sexual assault 143,000
Robbery 129,000
Assault 141,000
Other violent 38,000
Other property 17,000
Car theft 9,000
Theft 32,000
Burglary 86,000
Fraud 16,000
Drug possession 40,000
Other drugs 106,000
Driving Under the Influence 18,000
Other Public Order 64,000
Weapons 42,000
Other 8,000
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 10,000
Immigration Detention 32,000
Involuntary Commitment 22,000
Indian Country 2,000
Military 1,000
PRISON POLICY INITIATIVE
Sources and data notes: See https://www.prisonpolicy.org/reports/pie2022.html

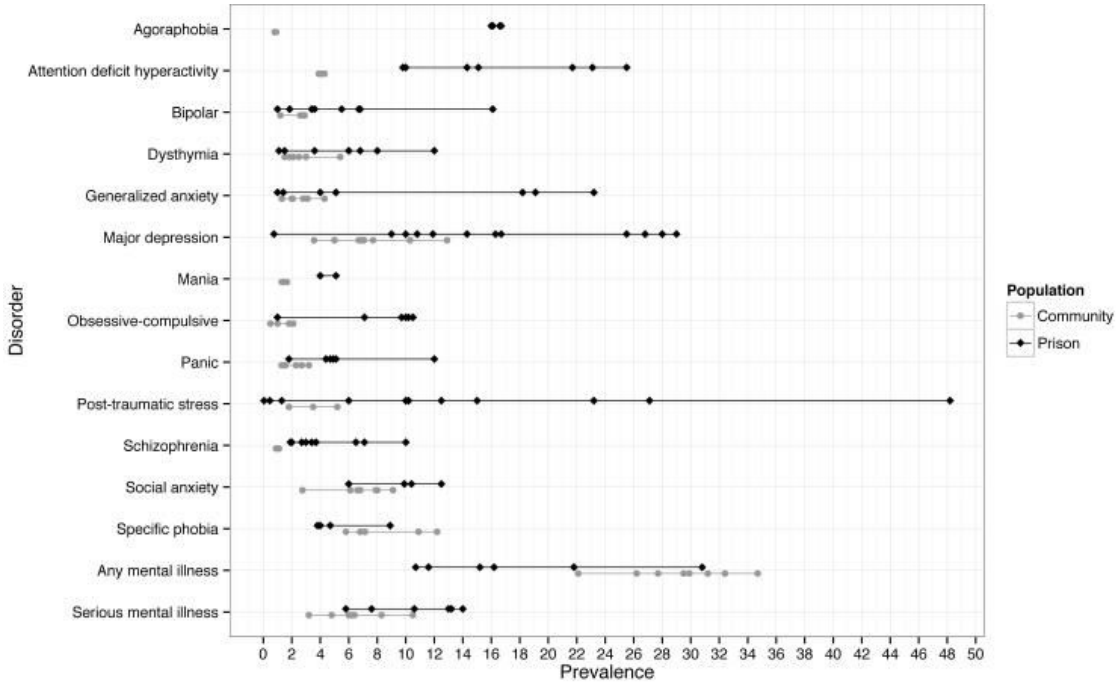

THE SENTENCING PROJECT
U.S. State and Federal Prison Population, 1925-2019
Number of People
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
1925
1932
1936
1940
1944
1948
1952
1956
1960
1964
1968
1972
1976
1980
1984
1988
1992
1996
2000
2004
2008
2012
2016
2019

People With Tremendous Health Needs



Prins, Psych Serv 2014

People With Tremendous Health Needs



Prins, Psych Serv 2014

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

Andrew Nixon / Capital Public Radio

Opinion > Doing Time: Healthcare Behind Bars

Why I Gladly 'Waste My Talents' in Prison

— Inmates can't go out for quality medical care -- care has to come to them

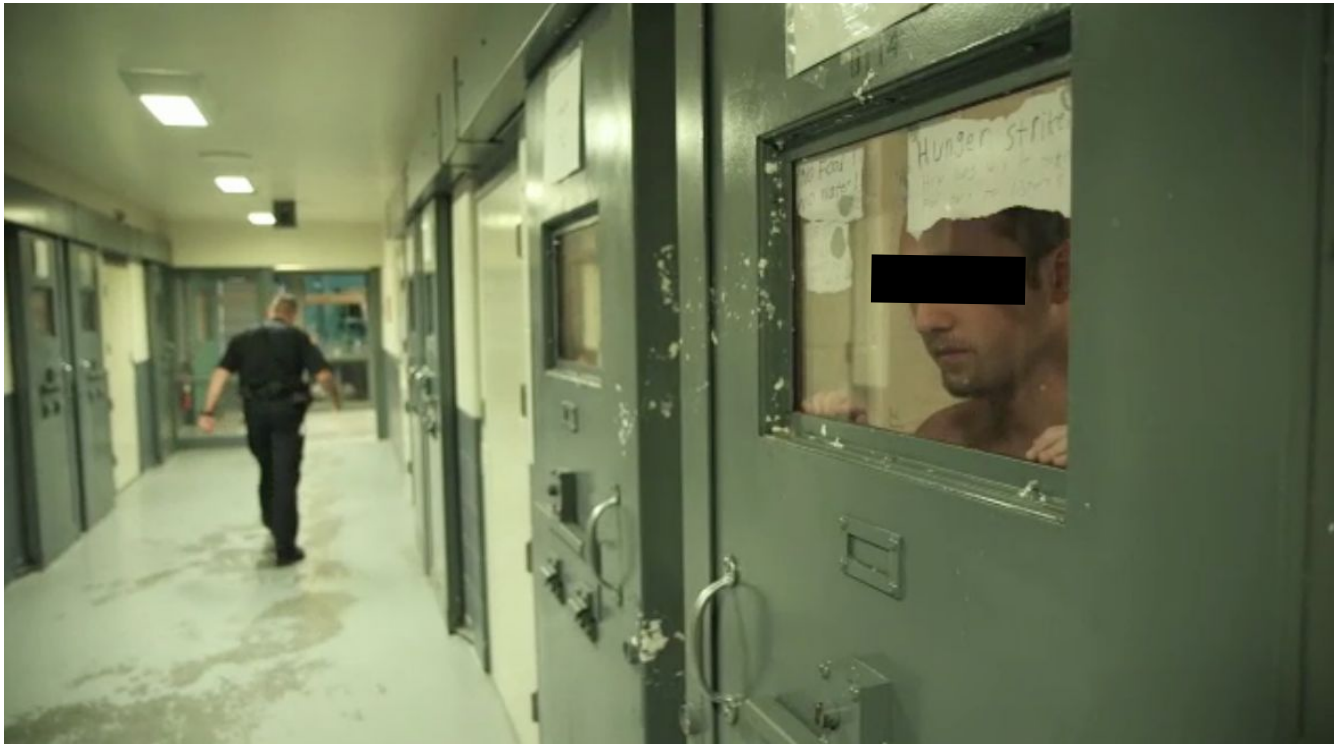
by Jeffrey E. Keller, MD
June 7, 2018

"Of course I work in a jail! That's where the sick and needy people are! Why aren't you working in a jail?"

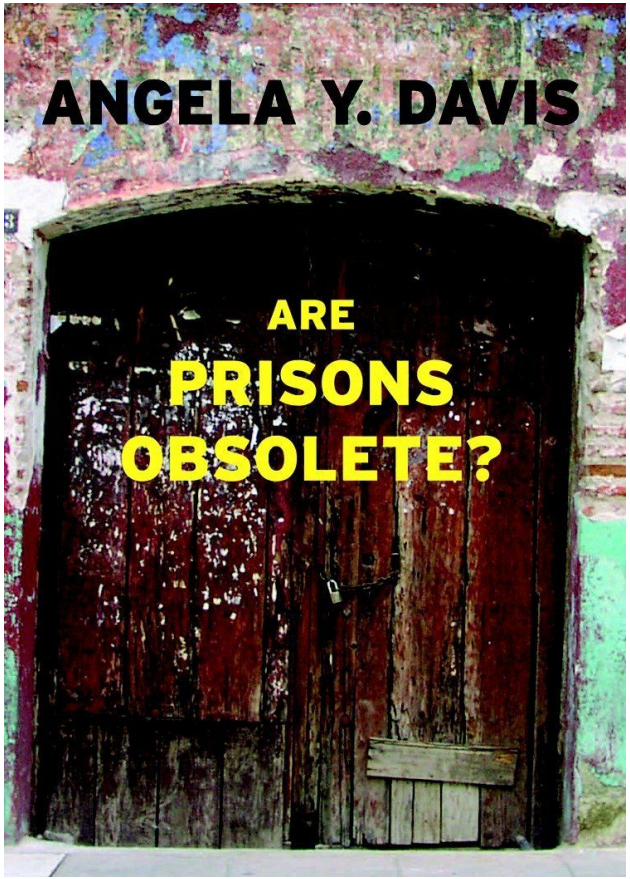
Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. **Mental Health Professionals Should Work in Jails and Prisons**
    a. Incarcerated People are People (With Tremendous Health Needs)
    b. **The Need for Health Care Right Now**
4. Paths Forward
5. Conclusions

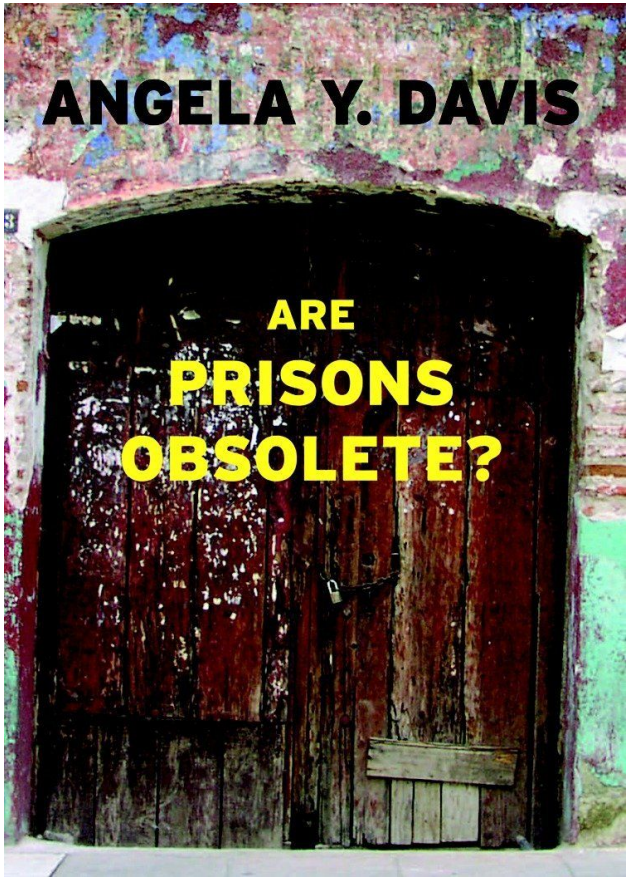
Jose Carlos Fajardo / Bay Area News Group



Last Days of Solitary / PBS



“The prison is considered so ‘natural’ that **it is extremely hard to imagine life without it**.”



“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 Need for Health Care Right Now

Pew Research Center

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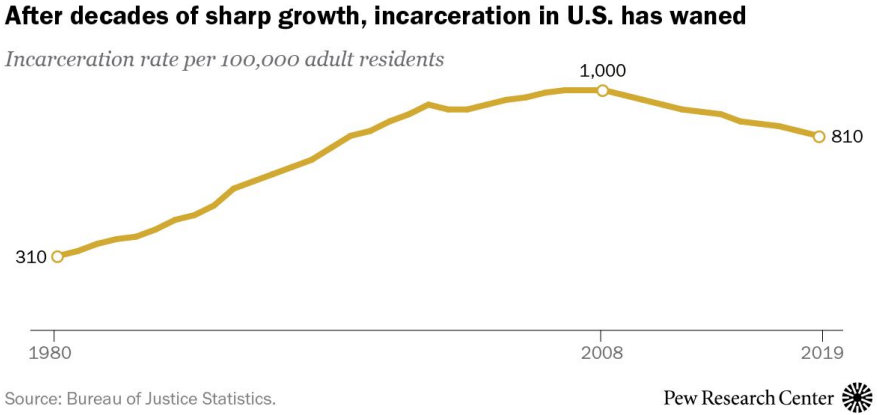
AUGUST 16, 2021

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.



The Need for Health Care Right Now

AP Photo / CDCR

The Need for Health Care Right Now

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.[5] 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**."

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. **Mental Health Professionals Should Work in Jails and Prisons**
    a. Incarcerated People are People (With Tremendous Health Needs)
    b. The Need for Health Care Right Now
    c. The Need for Advocacy
4. Paths Forward
5. Conclusions

The Need for Advocacy

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."

Ipsos

United States

Ipsos > News & Events : News > Doctors are the most trusted profession in the U.S. and across the world

Doctors are the most trusted profession in the U.S. and across the world

No people trust their military more than Americans do; trust in teachers steady globally but lower in the U.S. than before the pandemic.

12 October 2021 Public opinion / Trust in Professions

DOWNLOAD

New York, NY, October 12, 2021 — A new Ipsos poll finds doctors to be the world's most trustworthy profession. Across 28 countries where Ipsos asked the public how much they trust different professions, an average of 64% rate doctors as trustworthy, ahead of scientists (61%) and teachers (55%). In contrast, politicians are rated as trustworthy by only 10%, cabinet officials by 14%, and advertising executives by 15% on average globally.

nurse.org

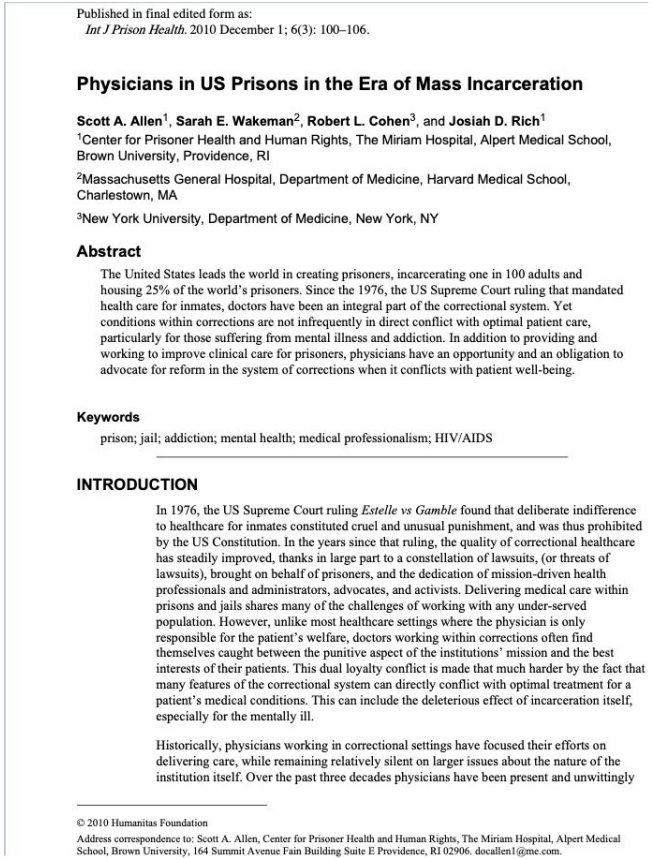
NEWS January 19, 2022

Nursing Ranked as the Most Trusted Profession for 20th Year in a Row

By: Kathleen Gaines

News and Education Editor, MSN, RN, BA, CBC

The Need for Advocacy



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]
[1]Center for Prisoner Health and Human Rights, The Miriam Hospital, Alpert Medical School, Brown University, Providence, RI
[2]Massachusetts General Hospital, Department of Medicine, Harvard Medical School, Charlestown, MA
[3]New York University, Department of Medicine, New York, NY

Abstract

The United States leads the world in creating prisoners, incarcerating one in 100 adults and housing 25% of the world's prisoners. Since the 1976, the US Supreme Court ruling that mandated health care for inmates, doctors have been an integral part of the correctional system. Yet conditions within corrections are not infrequently in direct conflict with optimal patient care, particularly for those suffering from mental illness and addiction. In addition to providing and working to improve clinical care for prisoners, physicians have an opportunity and an obligation to advocate for reform in the system of corrections when it conflicts with patient well-being.

Keywords

prison; jail; addiction; mental health; medical professionalism; HIV/AIDS

INTRODUCTION

In 1976, the US Supreme Court ruling *Estelle vs Gamble* found that deliberate indifference to healthcare for inmates constituted cruel and unusual punishment, and was thus prohibited by the US Constitution. In the years since that ruling, the quality of correctional healthcare has steadily improved, thanks in large part to a constellation of lawsuits, (or threats of lawsuits), brought on behalf of prisoners, and the dedication of mission-driven health professionals and administrators, advocates, and activists. Delivering medical care within prisons and jails shares many of the challenges of working with any under-served population. However, unlike most healthcare settings where the physician is only responsible for the patient's welfare, doctors working within corrections often find themselves caught between the punitive aspect of the institutions' mission and the best interests of their patients. This dual loyalty conflict is made that much harder by the fact that many features of the correctional system can directly conflict with optimal treatment for a patient's medical conditions. This can include the deleterious effect of incarceration itself, especially for the mentally ill.

Historically, physicians working in correctional settings have focused their efforts on delivering care, while remaining relatively silent on larger issues about the nature of the institution itself. Over the past three decades physicians have been present and unwittingly

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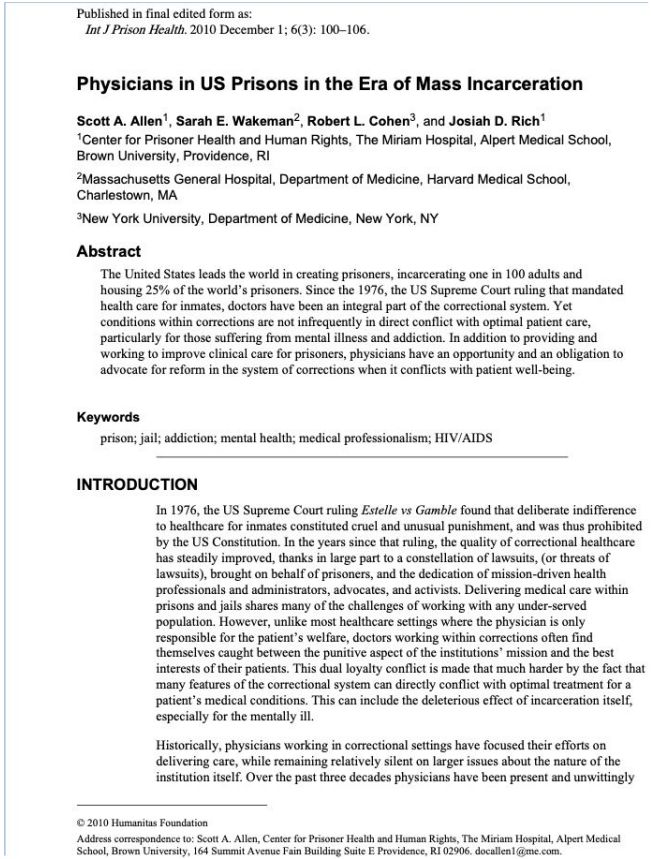
"The quality of health care in US prisons has improved dramatically in the past three decades in large part because **physicians and other health professionals brought the best ideals, skills and approaches of their professions to bear on medical challenges of their patients"**

The Need for Advocacy



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"The next step is to use these same professional assets to **produce positive reforms on conditions of confinement** that impact the health of their patients"

Trent Nelson / The Salt Lake Tribune

KQED

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California Prisons Chief Psychiatrist Says Hidden Data Exposes 'Broken System of Care'

LISTEN 01:15

By Julie Small Oct 31, 2018

Save Article

This article is more than 3 years old.

'Therapeutic modules' at California State Prison-Sacramento in 2014. *(Julie Small/KQED)*

THE NEW YORKER

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NEWS DESK

A RIKERS ISLAND DOCTOR SPEAKS OUT TO SAVE HER ELDERLY PATIENTS FROM THE CORONAVIRUS

By Jennifer Gonnerman

March 19, 2020

According to Rachael Bedard, a geriatrician at Rikers Island, which has two positive cases of the coronavirus, a prison is a perfect environment for an outbreak. Photograph from Redux

Rethinking the Criminalization of Personal Substance Use and Possession

Robert A. Kleinman, MD[1,2] *and Nathaniel P. Morris, MD*[3]

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J Gen Intern Med
DOI: 10.1007/s11606-021-06628-5

In November 2020, a majority of voters in Oregon approved a ballot measure to decriminalize personal possession of controlled substances. Once implemented, this measure would reclassify these offenses as non-criminal violations and replace criminal penalties with a $100 fine or the option of completing a health assessment at a designated treatment facility. The measure would also redirect cannabis-related tax revenues and criminal justice savings to fund addiction treatment services, among other programs. Oregon's ballot measure does not legalize commercial sale of all controlled substances for recreational use or expunge prior drug-related criminal records. Although some US cities and the District of Columbia have decriminalized personal substance use and possession (PSUP) of certain controlled substances beyond cannabis, such as psilocybin, Oregon is poised to become the first state to decriminalize PSUP of all controlled substances. While PSUP of controlled substances can incur federal criminal charges, enforcement of PSUP laws most often falls to state and local authorities.[1] The passage of Oregon's ballot measure thus represents a profound departure from traditional US policies toward PSUP, and its implementation warrants careful study given the potential to influence substance-related policy elsewhere.

The use of psychoactive substances is common in the USA. For some people, PSUP may be non-problematic or recreational. For others, PSUP may be secondary to a substance use disorder (SUD), which can involve significant functional impairment, morbidity, and mortality. The 2019 National Survey on Drug Use and Health (NSDUH) estimated that 165.4 million people aged 12 or older used substances in the month prior, including 139.7 million who drank alcohol, 58.1 million who used tobacco, and 35.8 million who used illicit drugs. Meanwhile, 20.4 million people aged 12 or older met criteria for a SUD, more than 70,000 died of drug-related overdoses.

Criminal justice systems across the country continue to put people in handcuffs, squad cars, police departments, courtrooms, jails, prisons, and probation and parole offices for PSUP. In 2019, there were more than 1.56 million arrests for drug-related offenses, of which 87% were for possession according to the Federal Bureau of Investigation (FBI). More than 249,000 people were under the jurisdiction of US federal and state correctional systems for drug-related offenses, including more than 46,000 people for possession, in 2018.[1] Surveys indicate that approximately 60% of individuals incarcerated in jails and state prisons meet diagnostic criteria for drug abuse or dependence.[2]

The selective criminalization of PSUP in the USA has disproportionately affected racial minorities. For example, the Anti-Drug Abuse Act of 1986 established a 5-year mandatory minimum sentence for possession of 5 grams of crack cocaine; the same sentence required 500 grams of powder cocaine, which is typically more expensive and likely to be used by affluent and White individuals.[3] A 2006 report estimated that more than 80% of defendants sentenced under federal crack cocaine laws were Black, even though more than 66% of crack cocaine users were White or Hispanic.[3] These types of disparities occur with other drugs as well. A study in Seattle found that 64% of individuals arrested for drug delivery between January 1999 and April 2001 were Black, despite a majority of drug deliveries being by White individuals.[4] From 1987 to 2014, there was over one arrest for drug possession per 100 Black adults each year; these annual rates of arrest were between 2.5 and 4.4 times greater than those for White adults, although evidence suggests Black and White adults use illicit substances at comparable rates.[5, 6] Being arrested can be frightening, stigmatizing, and potentially life-threatening. Moreover, an arrest may start a cascading sequence of legal involvement that can further perpetuate racial inequities: bail policies that determine who is detained pretrial, charging decisions by prosecutors, inadequate funding and shortages of public defenders, and sentencing disparities are among many aspects of the criminal justice system that may disproportionately affect minorities, as well as poor and other disadvantaged defendants, arrested for PSUP. Black and Hispanic individuals represent less than a third of the US population; still, among individuals under the jurisdiction of

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VIEWPOINT

COVID-19 in Prisons and Jails in the United States

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Cambridge Health Alliance, Cambridge, Massachusetts; and Harvard Medical School, Boston, Massachusetts.

Steffie Woolhandler, MD, MPH
Harvard Medical School, Boston, Massachusetts; and Hunter College, City University of New York, New York, New York.

Danny McCormick, MD, MPH
Cambridge Health Alliance, Cambridge, Massachusetts; and Harvard Medical School, Boston, Massachusetts.

In mid-March 2020, the first case of novel coronavirus 2019 (COVID-19) was diagnosed at Riker's Island, the main jail complex in New York City. Within 2 weeks, more than 200 cases were diagnosed within the facility, despite efforts to curb the spread. The situation at the Cook County jail in Chicago is similar, with about 350 incarcerated persons and staff members testing positive for the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus as of early April 2020. Many other jails and prisons have reported outbreaks of COVID-19 and related deaths.

Prior viral epidemics have wrought havoc in carceral settings. An account from San Quentin prison detailing the Spanish influenza of 1918 estimated that half of the 1900 inmates contracted the disease during the first wave of the epidemic; sick calls increased from 150 to 700 daily. Contrary to protocol, most of the ill were kept in the general prison population because the hospital ward was full.[1]

At present, jails (which house individuals awaiting trial or serving short sentences) and prisons (which house individuals who have been convicted of crimes and are serving longer sentences) are usually crowded. When they are unable to adhere to measures needed to contain and mitigate a viral epidemic, incarcerated persons, staff, and the wider community are endangered.

The Challenge of Social Distancing in Prisons and Jails

At San Quentin, a single incoming prisoner initiated each wave of the 1918 epidemic. Once introduced, the disease spread rapidly as a result of the inmates' close confinement and an inability to isolate the sick. The COVID-19 outbreak on the Diamond Princess cruise ship provides a contemporary analogy. With about 3700 passengers and crew held on board in separate but close quarters, about 700 people became infected and 12 died over a 4-week period. The rapid spread was attributed to a small number of kitchen workers housed together on Deck 3, who were responsible for feeding the quarantined passengers.[2] The infrastructure of most prisons and jails is similarly conducive to spreading disease. Moreover, people who are incarcerated will be at higher risk of exposure, as correctional officers and other staff frequently leave the facility and then return. In prisons and jails, social distancing is typically a physical impossibility.

Prisoners at High Risk for Severe Infection and Death

The elderly, and persons with underlying illnesses, are at high risk of severe illness and mortality from SARS-CoV-2 infection. As a result of longer sentences (mostly for non-violent offenses), the average age of the prison population has increased. In 2013, state prisons housed 131 500 persons older than 55 years, a 400% increase since 1993. Many incarcerated persons older than 55 years have chronic conditions, such as heart and lung diseases.[3] About half of the people incarcerated in state prisons have at least 1 chronic condition; 10% report heart conditions, and 15% report asthma, percentages far greater than those for the population at large, even when comparing similar age groups.[3]

Effects on Prison Health Care Systems

Few US prisons have health care systems able to accommodate a surge in sick calls similar to the situation at San Quentin during the Spanish influenza epidemic. Crowding and clinical vulnerability compound the barriers to adequate health care inherent in carceral settings. Although the US Constitution guarantees a right to health care for people who are incarcerated, available medical care varies greatly with regard to both access and quality, and services have been challenged by the increased needs of the aging prison population.[4] Incarcerated persons may be charged co-payments that are high relative to their wages, and this will deter their seeking care, although little revenue is generated. Moreover, when incarcerated persons do seek care, they often face long wait times for visits. The costs of hospital care, which prison systems bear, is a disincentive to referrals; several states have been scrutinized for providing substandard hospital-level care within their correctional systems.[5]

Solutions to Mitigate Harms

Even before COVID-19 cases were detected in prisons and jails, clinicians and advocates for incarcerated persons proposed measures to ameliorate the anticipated harms, such as the wide availability of protective equipment, testing and medical care, and the elimination of co-payments and other policies that may deter inmates from seeking care. Although these actions are essential, the most effective way to avoid an imminent outbreak, is, as others have argued, to drastically reduce the populations of jails and prisons.[6] Criminal justice systems can accomplish this by reducing unnecessary jail admissions and expediting prison release. Some prosecutors are already adjusting prosecutorial standards to reduce jail admissions and the length of stays. In Baltimore, prosecution of all drug possession and other minor crimes is being deferred. In San Francisco the district attorney has ordered the release of all persons in pretrial detention (who would be eligible for bail if they could afford it).[7] These steps may reduce crowding in some jails, but many other jails—and most prisons—are minimally affected.

Additional measures are required to reduce prison and jail populations. These include the release of those at high risk from COVID-19 owing to age or underlying conditions, those convicted of a nonviolent crime or in-

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San Francisco Chronicle

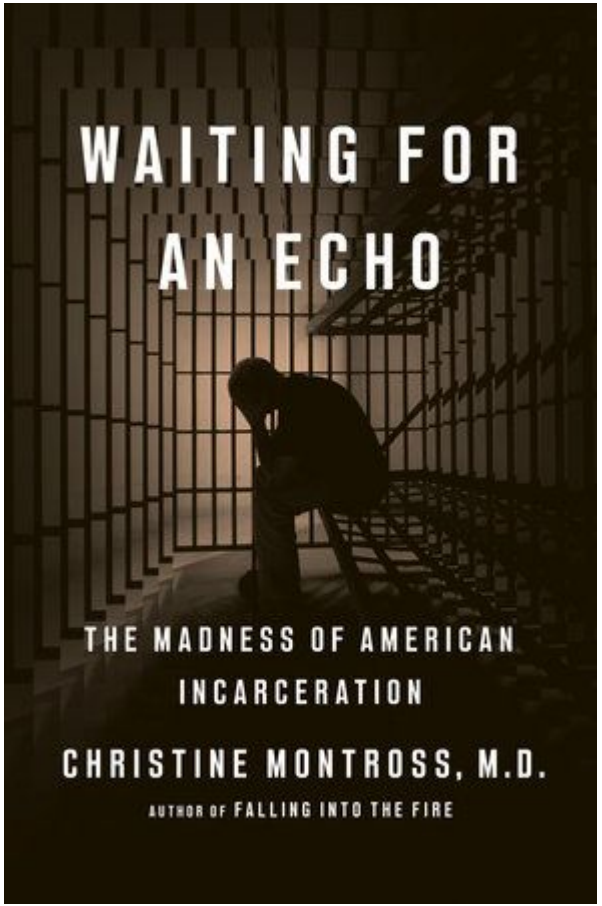
OPINION // OPEN FORUM

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. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. Mental Health Professionals Should Work in Jails and Prisons
4. **Paths Forward**
5. Conclusions

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. Mental Health Professionals Should Work in Jails and Prisons
4. **Paths Forward**
    a. **Expanding Medical Education About Incarceration**
5. Conclusions

Substance Abuse, Vol. 22, No. 2, 2001

Medical Education About the Care of Addicted Incarcerated Persons: A National Survey of Residency Programs

Mark L. Kraus, MD, FASAM,[1,2,8] J. Harry Isaacson, MD, FACP,[3,4] Ruth Kahn, DNSc,[5] Marlon P. Mundt, MA, MS,[6] and Linda Baier Manwell, BS[7]

In June 1998, there were 1.8 million inmates in correctional facilities for adults; 1.2 million in state and federal prisons and 600,000 in municipal/county jails (668 persons per 100,000 U.S. population). Rates of TB, AIDS, mental illness, and substance abuse are 2–13 times higher in persons living in jails and prisons. This study was designed to assess the level of training offered to residents in seven medical specialties in the care of addicted incarcerated persons. The study design involved two stages. The first entailed a mailed survey to 1,831 residency directors in family medicine, internal medicine, osteopathic medicine, pediatrics, obstetrics and gynecology, psychiatry, and emergency medicine. The second stage was a telephone interview, about substance use disorders, of faculty listed by the residency directors as teaching residents. The mailed survey was completed by 1,205 residency directors (66%). The 769 faculty from those identified programs, who participated in the telephone interview, reported that only 14% of their residency programs offered lectures or conferences on the care of incarcerated persons, yet 44% of the programs had residents caring for incarcerated persons with substance abuse problems, in a clinical setting. Only 22% offered clinical experiences for residents in a correctional facility.

We recognize that our survey of correctional health and substance abuse training is limited, but as such, a greater number of respondents to our survey do not teach residents addiction medicine topics pertaining to prevention, evaluation, intervention, and management of the addicted criminal offender/patient in a correctional setting or give adequate clinical exposure to this special population. The data suggests a need to

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[2]Yale University, School of Medicine, New Haven, Connecticut.
[3]Department of General Internal Medicine, Ohio State University, Cleveland, Ohio.
[4]Ohio State University, Cleveland, Ohio.
[5]Division of Medicine, Health Resources and Services Administration, Rockville, Maryland.
[6]Center for Addiction Research and Education, University of Wisconsin, Madison, Wisconsin.
[7]Center for Addiction Research and Education, University of Wisconsin, Madison, Wisconsin.
[8]To whom correspondence should be addressed at 714 Chase Parkway, Waterbury, Connecticut 06708; e-mail: marklk@home.com.

0889-7077/01/0600-0097$19.50/1

Survey of 1,205 residency directors across several specialties

14% offered lectures or conferences on care of incarcerated people

22% offered clinical experiences in a correctional facility

Article

Journal of Correctional Health Care
2019, Vol. 25(1) 37-44

DOI: 10.1177/1078345818820109
journals.sagepub.com/home/jcx
SAGE

A National Survey of Medical School Curricula on Criminal Justice and Health

Lisa Simon, DMD[1,2] and Matthew Tobey, MD, MPH[2,3]

Abstract

The number of U.S. medical schools that provide clinical training in correctional facilities or classroom-based training in criminal justice–related issues is unknown. This study consisted of an online survey of deans of education at U.S. schools granting an MD degree to assess teaching regarding criminal justice and health, and clinical training in correctional settings. We compared perceptions of such training and perceptions of graduate preparedness between programs with and without correctional health curricula. Institutions that offered instruction in correctional health were significantly more likely to agree that their graduates believe incarceration to be a social determinant of health and that their graduates are prepared to care for incarcerated patients. A substantial number of U.S. medical schools offer teaching that links health and criminal justice, though the extent of curricula varies significantly.

Keywords

medical education, correctional health, criminal justice, primary care

Introduction

More than 2.1 million Americans experience incarceration each year, and another 4.7 million are on probation or parole, higher proportions than in any other nation (Kaeble & Glaze, 2016). Incarceration disproportionately affects low-income, Latino, and Black individuals and communities, compounding preexisting disparities in health care access, outcomes, and overall well-being (Carson & Anderson, 2016).

People with a history of incarceration face barriers to good health before, during, and after incarceration. Incarcerated individuals have higher rates of chronic illness, infectious disease, and serious mental illness than the general population (Wildeman & Wang, 2017). Individuals often enter correctional facilities with multiple chronic illnesses and limited past access to the medical

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Email: matthew.tobey@mgh.harvard.edu

Survey including 49 US medical schools

51% offered a rotation in a correctional facility

23% had an explicit curriculum on criminal justice and health

The New Asylums / PBS

130.05 CIEx - Correctional Psychiatry in a Jail (1.5 - 3 units) Fall, Winter, Spring, Summer

Instructor(s): **L. Roth** *Prerequisite(s):* None
Restrictions: Medical students in Foundations 2
Activities: Direct - Clinical Experience/Patient Contact

This is a Bridges Curriculum Clinical Immersive Experience (CIEx), which provide medical students in Foundations 2 opportunities to broaden and enhance their professional development in health care settings different from those of their core clerkships. Students will become familiarized with outpatient psychiatric care in a jail setting, with exposure to new patient evaluations and follow up visits; severely mentally ill patients as well as those with less serious pathology and substance abuse.

140.01R Advanced Forensic Psychiatry - UCSF Parnassus - LPPI (6 units) Fall, Winter, Spring, Summer

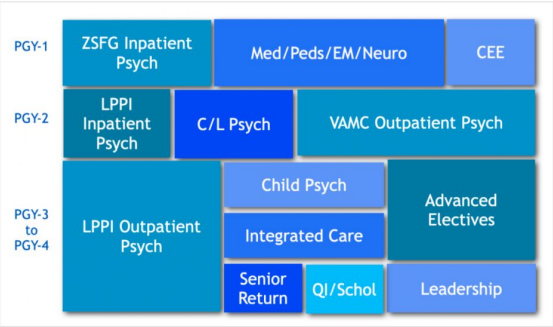
Instructor(s): **R. Binder, D. Li** *Prerequisite(s):* Psychiatry 110.
Restrictions: Final Year. Grading: Pass/No Pass.
Activities: Direct - Project, Direct - Independent Study, Direct - Conference, Direct - Clinical Experience/Patient Contact

Medical students will gain exposure to the field of forensic psychiatry through observation, active participation with forensic experts, and direct work with incarcerated patients. They will work at San Quentin State Prison two days/week and attend law school classes at Hastings College of Law when in session. They will learn about civil and criminal cases that involve psychiatric expertise and participate in a landmark case seminar that reviews cases at the interface of psychiatry and the law.

UCSF Weill Institute for Neurosciences | Department of Psychiatry and Behavioral Sciences

Clinical Experiences

Print PDF



UCSF emphasizes innovation and creativity, and the Adult Psychiatry Residency Program offers a clinical curriculum in which residents become expert clinicians and leaders in the field. The program provides broad exposure to a diversity of patients, modalities, therapies, and environments, while also highlighting longitudinal relationships with patients, faculty, and clinical systems.

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,

Outline

1. A Whispered Question
2. Mental Health Professionals Should Not Work in Jails and Prisons
3. Mental Health Professionals Should Work in Jails and Prisons
4. **Paths Forward**
    a. Expanding Medical Education About Incarceration
    b. **Supporting Clinicians Working Behind Bars**
5. Conclusions

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Staff Satisfaction, Ethical Concerns, and Burnout in the New York City Jail Health System

Ramneet Kalra, MPH, MBA[1], Sarah Glowa Kollisch, MPH[2], Ross MacDonald, MD[2], Nathaniel Dickey, MA, MPH[2], Zachary Rosner, MD[2], and Homer Venters, MD[2]

Abstract

This article reviewed a program evaluation conducted among correctional health care staff in New York City (NYC) using a 68-question electronic survey to assess satisfaction, attitudes, and beliefs in relation to ethics and burnout of health care employees in NYC jails. Descriptive statistics were tabulated and reviewed, and further assessment of burnout and ethics was performed through group sessions with participants. This evaluation has led to changes in agency policies and procedures and an emphasis on the human rights issue of the dual loyalty challenges that the security setting places on the overall mission to care for patients.

Keywords

health care staff, job satisfaction, attitude, ethics, job burnout

Introduction

Correctional health services in jails and prisons serve patients with high levels of morbidity and poor access to care in their communities (Castle, 2008; Flanagan & Flanagan, 2002). The approximately 12 million persons who cycle through jails and prisons annually receive a great deal of care, often delivered in stressful and challenging circumstances. For correctional health providers, the care they deliver may occur in traditional health clinics found within jails and prisons but may also be delivered in housing areas or other settings that are unfamiliar to most health care professionals. In addition, the nature of providing health care to the incarcerated creates unique pressures that can strain the traditional patient–provider bond (Garland, 2002; Ghaddar, Ronda, & Nolasco, 2011; Hemmens & Stohr, 2000). Security staff or the security setting may create dual loyalty challenges

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24% felt **their ethics as a health care provider were regularly compromised** by their work environment

33% **felt burnt out** by their work

frontiers in Psychiatry

ORIGINAL RESEARCH
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Mental Health of Staff at Correctional Facilities in the United States During the COVID-19 Pandemic

*M. Haroon Burhanullah[1], Pamela Rollings-Mazza[2], Jeffrey Galecki[1], Michael Van Wert[1], Thomas Weber[2] and Mansoor Malik[1]**

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Background: Although United States (US) correctional workers (correctional officers and health care workers at correctional institutions) have experienced unprecedented stress during the COVID-19 pandemic, to date, there are no systematic data on the mental health impact of COVID-19 on correctional workers.

Objective: To determine the perceived mental health burden of the COVID-19 pandemic on correctional workers and to explore the relationship between workers' mental health, social demographics, and environmental/work factors. In particular, the study sought to examine if occupational role (correctional officers vs. health care workers) or sex were associated with mental health status.

Methods: This cross-sectional survey was conducted in 78 correctional sites in Pennsylvania, Maryland, West Virginia and New York from November 1 to December 1, 2020. There were 589 participants, including 103 correctional officers and 486 health care workers employed at the correctional facilities. Measurements included the Patient Health Questionnaire-9, Generalized Anxiety Disorder-7, Adult PROMIS Short Form v.1.0—Sleep Disturbance, Impact of Event Scale-Revised, Maslach Burnout Inventory 2-item, and Connor-Davidson Resilience Scale 2-item.

Results: Approximately 48% of healthcare workers and 32% of correctional officers reported mild to severe depressive symptoms, 37% reported mild to severe anxiety symptoms, 47% of healthcare workers and 57% of correctional officers reported symptoms of burnout, and 50% of healthcare workers and 45% of correctional officers reported post-traumatic stress symptoms. Approximately 18% of healthcare workers and 11% of correctional officers reports mild to moderate sleep disturbance. Health care workers had significantly higher depression and sleep disturbance scores than did correctional officers, while correctional officers had significantly higher burnout scores. Female correctional workers scored significantly higher on anxiety than their male counterparts. Increased workload, workplace conflict, younger age of employees, trust in institutional isolation practices, and lower work position were associated with increased burnout. Despite experiencing high mental health burden, correctional workers showed high resilience (60%).

"Our findings suggest that correctional workers **face high psychological morbidity amid unique challenges in the correctional environment"**

Supporting Clinicians Behind Bars

- Training on dual loyalty and ethical dilemmas
- Confidential reporting pathways
- Adequate staffing
- Private spaces for patient care
- Support groups and counseling services

Outline

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    c. Taking on Leadership Roles in Jails and Prisons
5. Conclusions

Prison Health Care Governance: Guaranteeing Clinical Independence

Clinical independence is an essential component of good health care and health care professionalism, particularly in correctional settings (jails, prisons, and other places of detention), where the relationship between patients and caregivers is not based on free choice and where the punitive correctional setting can challenge optimal medical care.

Independence for the delivery of health care services is defined by international standards as a critical element for quality health care in correctional settings, yet many correctional facilities do not meet these standards because of a lack of awareness, persisting legal regulations, contradictory terms of employment for health professionals, or current health care governance structures.

We present recommendations for the implementation of independent health care in correctional settings. (*Am J Public Health*. 2018;108:472–476. doi: 10.2105/AJPH.2017.304248)

Jörg Pont, MD, Stefan Enggist, MA, Heino Stöver, PhD, Brie Williams, MD, MS, Robert Greifinger, MD, and Hans Wolff, MD, MPH

See also Wynia, p. 440.

In 2015, more than 10 million individuals were incarcerated worldwide at any one time. Approximately 30 million individuals enter prisons each year,[1] and many thousands more migrants and asylum seekers are detained.[2] The provision of health care for detained persons (those living in correctional settings, including prisons, jails, and other places of detention) has several pervasive, though not unique, characteristics. First, the state is responsible for delivery of all health care, which, legally or de facto, is the same entity responsible for rescinding liberty. Second, on average, detained persons have higher rates of morbidity and thereby greater health care needs than nondetained persons.[3,4] Additionally, cramped and sometimes overcrowded living conditions, common in correctional and detention facilities, carry health risks both for inmates and for the communities to which most will one day return.[5] The primary purposes of correctional facilities include separating the individual from society to serve a sentence and maintaining safety and security through administrative control. Each of these purposes can pose a challenge to the provision of high-quality health care. Finally, detained patients cannot choose their health care professionals.

Behind bars, it is not uncommon for health professionals to have a conflict between a primary duty to care for the health and well-being of patients and a secondary duty to follow the rules of prison management, whereby prisoners are not primarily patients but rather objects of surveillance, punishment, or rehabilitation. Therefore, health professionals often have a dual loyalty to their patients and to the institution.

There are a number of ethical, organizational, and structural barriers that are common in correctional health care. These include conflicts related to dual loyalty for health professionals; the provision of health care that is equivalent to the community standard in a unique health care delivery system; the assurance of timely access to health care professionals despite the competing demands of security in the facility; and the clinical independence of health care staff to ensure that the decisions made are in the best interests of their patients.[6–9]

The aims of this essay are to illuminate the importance of independent health care services in correctional settings and to provide recommendations for the implementation of independent health care services in correctional settings.

LEGAL AND ETHICAL BASIS

The World Medical Association (WMA) defines "clinical independence" as the "assurance that individual physicians have the freedom to exercise their professional judgment in the care and treatment of their patients without undue influence by outside parties or individuals," and it "is a critical component of high quality medical care and an essential principle of health care professionalism."[10] This is of particular importance in correctional and detention settings, where the relationship between health care providers and patients is not based on free will.[11]

ABOUT THE AUTHORS

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INSIDE OUT

Prisons Have a Health Care Issue — And It Starts at the Top, Critics Say

When coronavirus hit federal prisons, the top officials had no health care experience.

ANJALI NAIR/NBC NEWS

FILED 6:00 a.m. 07.01.2021

By KERI BLAKINGER

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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]
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Abstract

The United States leads the world in creating prisoners, incarcerating one in 100 adults and housing 25% of the world's prisoners. Since the 1976, the US Supreme Court ruling that mandated health care for inmates, doctors have been an integral part of the correctional system. Yet conditions within corrections are not infrequently in direct conflict with optimal patient care, particularly for those suffering from mental illness and addiction. In addition to providing and working to improve clinical care for prisoners, physicians have an opportunity and an obligation to advocate for reform in the system of corrections when it conflicts with patient well-being.

Keywords

prison; jail; addiction; mental health; medical professionalism; HIV/AIDS

INTRODUCTION

In 1976, the US Supreme Court ruling *Estelle vs Gamble* found that deliberate indifference to healthcare for inmates constituted cruel and unusual punishment, and was thus prohibited by the US Constitution. In the years since that ruling, the quality of correctional healthcare has steadily improved, thanks in large part to a constellation of lawsuits, (or threats of lawsuits), brought on behalf of prisoners, and the dedication of mission-driven health professionals and administrators, advocates, and activists. Delivering medical care within prisons and jails shares many of the challenges of working with any under-served population. However, unlike most healthcare settings where the physician is only responsible for the patient's welfare, doctors working within corrections often find themselves caught between the punitive aspect of the institutions' mission and the best interests of their patients. This dual loyalty conflict is made that much harder by the fact that many features of the correctional system can directly conflict with optimal treatment for a patient's medical conditions. This can include the deleterious effect of incarceration itself, especially for the mentally ill.

Historically, physicians working in correctional settings have focused their efforts on delivering care, while remaining relatively silent on larger issues about the nature of the institution itself. Over the past three decades physicians have been present and unwittingly

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"Physicians are often part of the leadership and management of correctional institutions. Physicians in administrative positions have an affirmative duty to **use their knowledge about the effects of correctional programs on the health of their patients to help inform and guide prison leadership"**

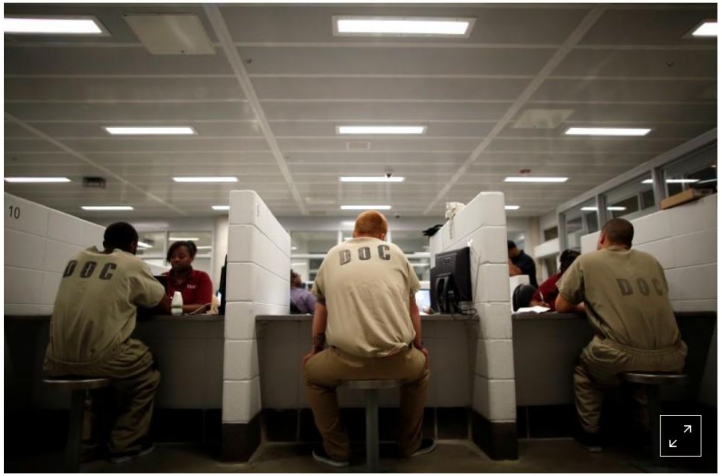
REUTERS

U.S. NEWS MAY 19, 2015 / 4:10 AM / UPDATED 7 YEARS AGO

Psychologist to head Chicago jail, nation's second largest

By Mary Wisniewski 3 MIN READ

CHICAGO (Reuters) - A clinical psychologist will be appointed head of Chicago's Cook County Jail, the nation's second-largest jail where a third of the inmates are mentally ill, officials announced on Tuesday.



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Awards and Appreciation
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Obituaries
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Unlocking History

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CDCR New Releases

Beyond the Badge

Mental health providers put patient care first

JUNE 9, 2022

Dr. Amar Mehta oversees the statewide Mental Health Program for CDCR.

Each May, communities observe Mental Health Awareness Month, which emphasizes the importance of treatment and the impact trauma can have on the physical, emotional, and mental well-being of children, families, and communities. But for the dedicated employees of the CDCR's Statewide Mental Health Program (SMHP), mental health is top-of-mind 24 hours a day, seven days a week.

CDCR has about 97,000 people incarcerated in 33 institutions, and of that population, about 30,000 receive some level of mental health care. A team of about 6,000 clinicians and support staff work around the clock ensuring incarcerated patients receive mental health care. At the helm of the SMHP is Deputy Director Dr. Amar Mehta. He will be the first to say he is not the secret to success – it's the clinicians and support staff at the institutions.6

"We are not the center – they are the center," Mehta said. "We are here to assist them (and) are partners in this. The only reason I have my job is to support the institutions in providing the best care."

Overview of Mental Health Program

Outline

1. A Whispered Question
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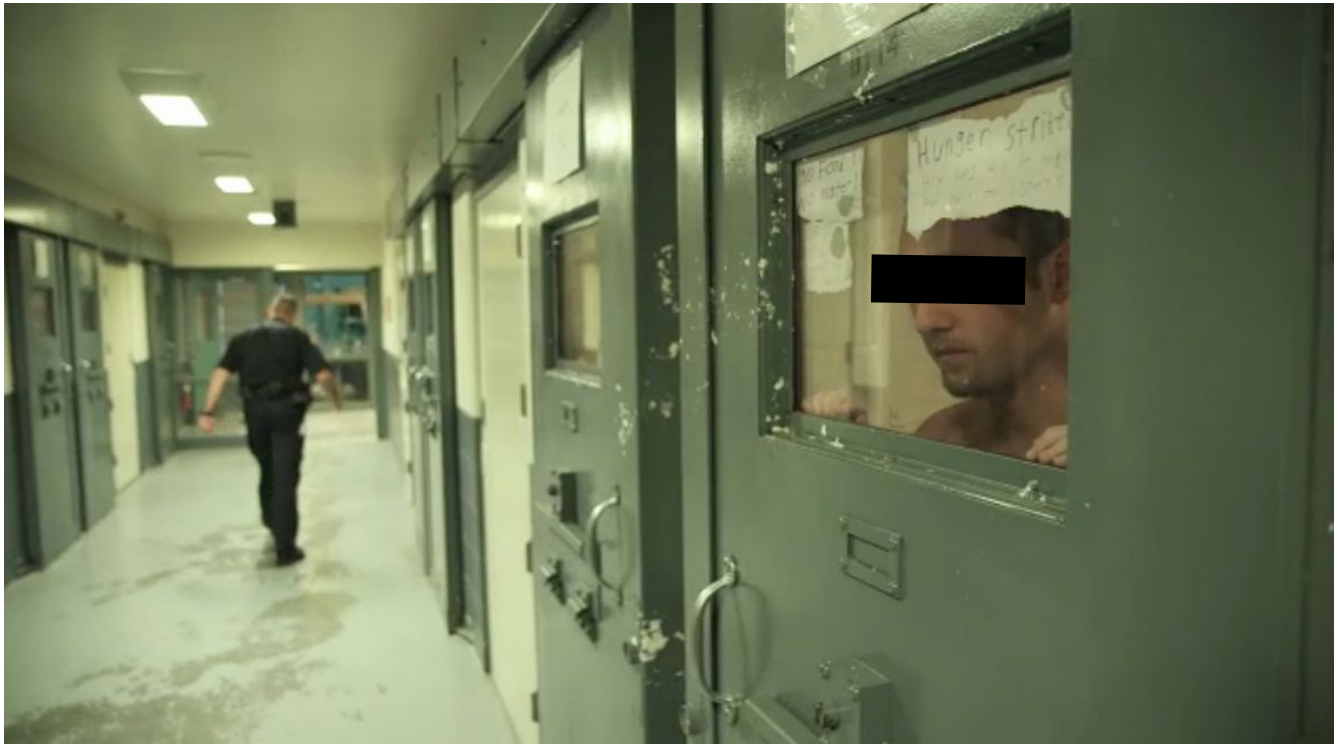
    a. Expanding Medical Education About Incarceration
    b. Supporting Clinicians Working Behind Bars
    c. Taking on Leadership Roles in Jails and Prisons
    d. Talking with Patients About Incarceration
5. Conclusions



Last Days of Solitary / PBS

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**"

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**"

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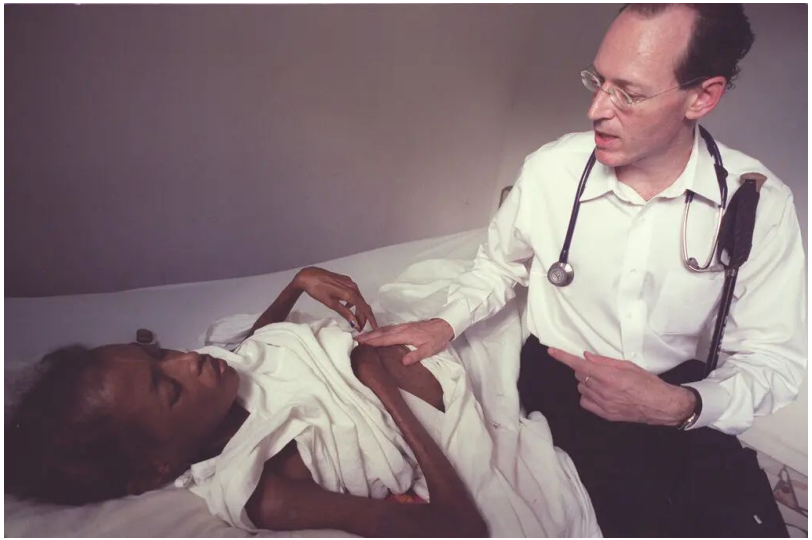
4. Paths Forward
5. **Conclusions**

“It is said that no one truly knows a nation until one has been inside its jails. **A nation should not be judged by how it treats its highest citizens, but its lowest ones.”**

Jurgen Schadeberg / Getty Images



Angel Franco/The New York Times

“For me, an area of moral clarity is: you're in front of someone who's suffering and you have the tools at your disposal to alleviate that suffering or even eradicate it, **and you act.”**

Questions?

UCSF
University of California
San Francisco