

Misconceptions About Working in Correctional Psychiatry

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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.

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

Like other institutions that provide health care, correctional facilities may encounter difficulties retaining MHPs over the long term, particularly because MHPs are in demand and may have several options to work elsewhere.³ Many MHPs, however, are not willing to work in correctional facilities in the first place. In a 2007 study of approximately

170 graduate students at counseling and clinical psychology programs accredited by the American Psychological Association, fewer than 30 percent agreed that they were willing to consider or were planning on a forensic or correctional career.⁵ In surveys of 134 Canadian psychiatry residents, conducted between 2009 and 2011, 28 percent agreed with the statement, “I would be likely to try to avoid offering consultation or treatment to individuals in prison” (Ref. 6, p 419). When asked in a 2012 study whether U.S. jails need psychiatrists, 44 residents from a Texas psychiatry residency program responded with a mean score of 84, where 100 indicated total agreement; yet, when asked how likely they were to work in a jail after residency, residents provided a mean response of 22.⁷

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

Incarcerated patients are less deserving of mental health care than other patients.

Working in correctional psychiatry supports mass incarceration.

Correctional psychiatry is more dangerous than practicing psychiatry elsewhere.

Correctional psychiatry is a less respectable subspecialty.

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There are few teaching opportunities in correctional psychiatry.

There are few research opportunities in correctional psychiatry.

By examining these misconceptions, this article seeks to encourage recruitment into correctional psychiatry by adding nuance to these considerations and to counter potential misinformation.

Right to Mental Health Care

Some clinicians may believe that incarcerated individuals are less deserving of mental health care than other patients. Trainees in psychiatry and psychology often report negative views of criminal offenders or reluctance to treat these populations.⁵⁻⁸ A 2007 article about mental illness in prisons noted that, “Compared with the public, offenders may seem less cooperative, less appealing, and even less ‘human’” (Ref. 9, p 408). Ford wrote in her 2017 book that, “For most doctors, working behind bars with patients whom others see as criminals, inmates, even ‘bodies,’ is not very appealing” (Ref. 10, p vi). She later noted, “I get complaints that ‘my’ patients are taking up beds for people who really need them The message I hear is that forensic patients are less worthy of care” (Ref. 10, p 111).

Clinicians in training and in practice may wish to avoid working with incarcerated patients for various reasons, including stigma, personal experiences with crime, and safety concerns. Clinicians nevertheless have a duty to alleviate suffering wherever it takes place. Estimates suggest as many as 10 to 30 percent of incarcerated individuals have a mental disorder, and rates of mental disorders are generally higher among incarcerated individuals than in the general population.¹¹⁻¹⁵ Substance use disorders are highly prevalent in incarcerated individuals, often at greater rates than mental disorders.^{16,17} Incarcerated individuals also have elevated risks for suicide, self-harm, and victimization compared with nonincarcerated individuals.¹² Correctional psychiatry provides ample opportunities for clinicians to provide high-quality mental health care, including management of psychotropic medications, individual psychotherapy, and group psychotherapy.^{18,19} Despite stereotypes that criminal offenders are unappreciative or difficult, many incarcerated patients are grateful to see clinicians as a way to not only alleviate the daily monotony of in-

carceration but also to have meaningful human contact.

Courts in the United States have established that incarcerated individuals have a right to mental health care. After the landmark 1976 U.S. Supreme Court case *Estelle v. Gamble* established that deliberate indifference to serious medical needs violated incarcerated individuals’ constitutional rights,²⁰ the U.S. Court of Appeals for the Fourth Circuit concluded in the 1977 case *Bowring v. Godwin* that “we see no underlying distinction between the right to medical care for physical illness and its psychological or psychiatric counterpart” (Ref. 21, p 47). Since then, incarcerated individuals have pursued wide-ranging litigation over access to mental health care.²² As noted in a 2012 article, “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. The truth is that there are numerous cases in which prisoners have been denied much-needed medical attention” (Ref. 23, p 414).

Mass Incarceration

Concerns about supporting mass incarceration may deter MHPs from correctional psychiatry. In a 2010 article, Allen *et al.*²⁴ noted that “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” (Ref. 24, p 103). Correctional facilities place varying emphasis on rehabilitation, as opposed to retribution, and MHPs who encounter harsh conditions of imprisonment, such as solitary confinement, may wonder whether their own presence in correctional facilities enables these forms of punishment.²⁴⁻²⁷ Clinicians in correctional psychiatry must grapple with dual loyalties to their patients and to correctional systems, which can raise ethics dilemmas in light of potentially conflicting missions.²⁸⁻³¹ Outside of correctional facilities, the treatment of incarcerated patients in community health care settings can involve atypical protocols, such as the shackling of patients, the presence of correctional officers, and the use of alternative patient care areas, and clinicians might feel conflicted about providing care in these situations.³²⁻³⁶ Moreover, clinicians may not have input in these logistical decisions and may feel dis-

tressed at their lack of autonomy in these circumstances.

Although many correctional systems cannot function without the support of MHPs, clinicians are not law enforcement officers, and their roles do not include facilitation of incarceration. Rather, their roles are to alleviate suffering among people with mental illness, and turning away from correctional psychiatry also means turning away from hundreds of thousands of incarcerated individuals with mental illness.¹¹ In their 2010 article, Allen *et al.* also argued that “physicians are obliged to advocate for appropriate health services for their prisoner patients” and that physicians can use their “professional assets to produce positive reforms on conditions of confinement that impact the health of their patients” (Ref. 24, pp 102–03). Potential areas of advocacy for clinicians in correctional psychiatry include seeking to enhance access to evidence-based psychiatric treatments, speaking out against inhumane conditions of confinement (e.g., extended solitary confinement), and helping develop alternatives to incarceration for offenders with mental disorders or substance use disorders.^{25–27}

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, MHPs can use their skills to heal patients with some of the greatest needs and to change the criminal justice system from within toward a greater focus on prevention and rehabilitation.

Safety Concerns

Clinicians may be reluctant to work in correctional settings because of safety concerns.^{5–7,37,38} In the 2007 study of psychology graduate students, 71 percent agreed or strongly agreed that safety was “an important aspect in willingness to work in a forensic/correctional setting” (Ref. 5, p 103). The 2012 study of Texas psychiatry residents found that trainees were significantly more likely to worry about being assaulted at work in a jail compared with an inpatient psychiatry setting.⁷ In a 2017 article on psychiatric education in correctional settings, Holoyda and Scott wrote that, “issues need to be addressed if there is going to be a future psychiatric workforce to face the growing clinical needs of

correctional facilities. Perhaps most important among these matters is trainees’ perception of safety” (Ref. 38, p 17).

A 2014 article about clinical training in correctional psychiatry stressed that safety concerns cannot be dismissed.³⁹ Psychiatry trainees and practitioners might reasonably worry about safety in correctional settings because many individuals are indeed incarcerated for violent offenses. For example, 55 percent of state prisoners in the United States were serving sentences at the end of 2016 for violent offenses.⁴⁰ Moreover, correctional institutions regularly report among the highest rates of occupational injuries and illnesses compared with other industries.⁴¹

Working in correctional psychiatry involves safety risks, but it is unclear whether these risks are necessarily greater than working in other health care settings. According to 2017 data, the incidence of nonfatal occupational injuries and illnesses per 100 workers was 7.9 in state correctional institutions compared with 10.9 in state nursing and residential care facilities, 7.8 in private psychiatric and substance abuse hospitals, and 7.7 in state hospitals.⁴¹ A study in Denmark found that psychiatric workers were significantly more likely to report threats and physical violence than workers in prison and probation services.⁴² These statistics do not negate the safety risks of correctional work but suggest that clinicians also face safety risks elsewhere by virtue of working in mental health care. A 2012 systematic review of nine studies reported that 25 to 64 percent of psychiatry residents had been physically assaulted as part of their work.⁴³ A survey published in 2017 of 323 clinical staff at a California public psychiatric hospital noted that 70 percent had been physically assaulted during the prior 12 months.⁴⁴

In 2016, the American Psychiatric Association Council on Psychiatry and Law published a resource document encouraging psychiatrists to work in jails and prisons, in which safety concerns were addressed: “Though there is little published on this subject, the consensus experience of the Authors is that the risk of a psychiatrist being assaulted or injured in a jail or prison setting, where security is a primary objective, is lower than in busy emergency rooms or some inpatient hospital settings” (Ref. 45, p 7). Correctional facilities typically have numerous safeguards that protect clinicians, including correctional officers monitoring incarcerated patients, metal detectors and other searches screening for contraband (e.g.,

weapons, drugs), sally ports controlling the flow of persons between areas, and panic buttons providing the option to immediately notify colleagues of safety concerns. Correctional facilities are one of the few settings in which MHPs work where many, if not most, staff are hired solely for the purpose of maintaining safety. This focus on security could be one reason why the safety risks in correctional psychiatry might not be greater than working in other psychiatric settings.³⁹ Several clinicians have written about feeling safer when working in correctional institutions than while working in other health care settings, such as emergency departments or community psychiatry clinics.⁴⁵⁻⁴⁷

Respect for the Subspecialty

For decades, clinicians have been looked down upon for practicing medicine in correctional settings. A 1979 article pointed out that correctional psychiatry was “associated with low professional status and poor working conditions” (Ref. 48, p 157). A 1998 newspaper article noted that “[p]rison and jail doctors get little public and professional respect . . . [partly] from the misguided belief that all physicians who work behind bars cannot get a job elsewhere” (Ref. 49, p G9). Mental health professionals may believe that correctional psychiatry is an undesirable career path, a field for clinicians who are less qualified or who have disciplinary records.⁵⁰⁻⁵² Writing in a 2017 book about treating incarcerated patients with mental illness, Ford expressed concern that others viewed her as “less worthy as a doctor” (Ref. 10, p 111). In 2018, a physician working in correctional settings wrote, “I personally have heard the ‘you’re wasting your talents’ line more than once” (Ref. 53, p 1).

Yet these kinds of perceptions may be shifting. There is increasing recognition that “mental illness in the criminal justice system is one of the most important and underserved public health challenges” (Ref. 39, p 680), and that MHPs in correctional psychiatry work among the front lines of U.S. mental health care. As summarized by Fuehrlein *et al.* in 2012, “[T]he need for mental health care in jails and prisons is a national phenomenon” (Ref. 7, p 756). A 2016 report noted that “the Los Angeles County Jail, Chicago’s Cook County Jail, or the New York’s Riker’s [sic] Island Jail Complex each hold more mentally ill inmates than any remaining psychiatric hospital in the United States” (Ref. 11, p 1).

Rather than working in correctional facilities as a last resort, many clinicians choose to work in these settings due to the unique opportunities to help disadvantaged, high-risk populations. As one correctional physician wrote in 2018, “Of course I work in a jail! That’s where the sick and needy people are” (Ref. 53, p 3). Incarcerated individuals may come from backgrounds with limitations in health literacy, financial resources, housing, and access to health care, and incarceration can further exacerbate health disparities in their home communities.⁵⁴⁻⁵⁷ Mental health professionals who work in correctional settings have remarkable opportunities to lessen these disparities and to learn from patients about cultural factors (such as language, tattoos, racial divisions, and socioeconomic disparities) related to criminal justice involvement.^{55,58} Developing these kinds of cultural competencies can be key when caring for patients with criminal histories, whether during or after incarceration. As one of this article’s authors wrote in 2018, “understanding the experience of mental illness in the United States can be difficult without talking with patients about their interactions with the legal system” (Ref. 59, p 750).

Correctional psychiatry has undergone a transformation in professional standing during recent years. In a 2016 book chapter, Barboriak wrote that, “the twenty-first century witnessed the maturation of correctional psychiatry into a distinct subspecialty” (Ref. 60, p 517), noting the development of academic publications, training rotations, practice guidelines, and accrediting processes related to the field. Today, MHPs are highly sought after to work in correctional psychiatry, whether on a part-time or full-time basis, and “compensation for correctional work is usually quite competitive” (Ref. 45, p 6).

Teaching Opportunities

Clinicians might worry that working in correctional psychiatry precludes teaching opportunities. Organizing training opportunities in correctional settings can be challenging. In a 2014 study of 95 psychiatry training directors, respondents provided a mean score of 2.4, where 1 indicated most negative and 5 indicated most positive, when asked how logistically difficult it would be to arrange correctional rotations.⁶¹ Training directors provided responses such as “no room in schedule,” “no interest,” “no funding,” “distance,” and “poor learning envi-

ronment,” among other concerns. A 2017 article noted “substantial potential barriers to coordinating correctional training experiences, including both programme directors’ and residents’ concerns regarding safety and enjoyment and negative perceptions of inmate and prisoner patients” (Ref. 38, p 11). A 2018 article examined barriers to developing forensic rotations for general psychiatry residents, including regulatory challenges, logistical (e.g., scheduling, confidentiality, geographic) difficulties inherent to forensic work, and the potential lack of resources that residency programs might have to develop new rotations.⁶²

Still, correctional psychiatry offers abundant opportunities for clinicians who wish to teach trainees. A 2013 study noted that 57 percent of responding doctoral programs in clinical and counseling psychology offered practicum opportunities in criminal justice settings.⁶³ The 2014 study of psychiatry training directors reported 55 percent of respondents offered required or elective rotations in correctional settings for their residents.⁶¹ Highly regarded psychiatry residency programs across the country, including at Massachusetts General Hospital/McLean,⁶⁴ New York University,⁶⁵ and the University of California, San Francisco,⁶⁶ incorporate correctional rotations into residents’ training. Recruiting trainees into correctional psychiatry remains a challenge, but research suggests that trainees are often interested in receiving teaching about forensic and correctional psychiatry,^{5,6,67-69} and U.S. psychiatry residency programs are located at an average distance of just four miles from the nearest correctional facility.⁷ Whether teaching trainees about working with limited drug formularies in jails and prisons, about conducting suicide risk assessments with incarcerated individuals, or about testifying in legal hearings related to psychiatric treatment, clinicians working in correctional psychiatry can serve as key instructors in the training of MHPs.^{39,70-72}

There are numerous teaching opportunities in correctional psychiatry beyond mentoring clinical trainees. Clinicians who care for incarcerated patients can serve as educators regarding mental health care in the U.S. criminal justice system. As pointed out by the American Psychiatric Association Council of Psychiatry and Law, “Psychiatrists working with justice-involved populations can channel their clinical expertise to . . . provid[e] informed—and pragmatic—guidance to state, county, and local officials,

determining how best to treat a growing population of incarcerated persons with mental illnesses” (Ref. 45, p 6). Clinicians can educate correctional staff, patients, and patients’ families about mental illness, addiction, psychiatric treatment, and other mental health topics that are often misunderstood and stigmatized among the public.

Research Opportunities

Clinicians may mistakenly believe that working in correctional psychiatry means giving up opportunities to conduct research. Conducting research on incarcerated individuals raises ethics concerns regarding autonomy, informed consent, and potential exploitation.^{73,74} Because of these concerns, incarcerated individuals are afforded special protections by U.S. federal regulations, including requirements that these individuals are aware that research participation will not affect parole consideration and that prisoner participants assume risks that nonprisoner participants would also be willing to accept.⁷⁵ Some researchers and members of institutional review boards may struggle to navigate these special regulations.⁷⁶

Even with these regulations, MHPs can perform high-impact research within correctional settings, such as studying the prevalence of mental disorders among incarcerated individuals,¹² overdose mortality after reentry to the community,⁷⁷ interventions to prevent suicidal behavior in prisons,⁷⁸ or different psychological therapies in correctional settings.¹⁹ Correctional psychiatry needs data upon which to ground its practices, and researchers can make a difference in correctional psychiatry by generating these kinds of data.⁷⁹

In just one example, researchers in the New York City jail system realized there was little information about the prevalence of traumatic brain injuries (TBI) among incarcerated adolescents. Over the course of 12 months, researchers screened 384 adolescents on admission to the New York City jail system for TBI, finding that approximately 50 percent had experienced a prior TBI.⁸⁰ A follow-up study published in 2017 examined 42 months of electronic health record data from adolescents and adults in the New York City jail system, identifying 10,286 incidents of head trauma and 1,507 incidents of mild TBI.⁸¹ Estimating that the rate of mild TBI in the New York City jail system was more than 50 times greater than estimates from community samples, the

authors called for a national reporting system on TBI in jails and prisons and concluded that head trauma is “a significant and underreported health problem among the incarcerated” (Ref. 81, p 1047).

There is a tremendous need to understand better the mental health burdens, as well as the prevention and treatment opportunities, among incarcerated populations. Clinicians can achieve these aims and improve the practice of psychiatry by conducting research in correctional settings.

Conclusions

There are persistent shortages of MHPs in U.S. correctional facilities, and misconceptions about correctional psychiatry deter clinicians from working in the field. Clinicians may develop impressions about correctional psychiatry early in their training, suggesting that training experiences might be critical periods for exposing MHPs to correctional psychiatry and correcting misinformation about the field. The Accreditation Council for Graduate Medical Education requires that all psychiatry residents have forensic psychiatry experiences in “evaluating patients’ potential to harm themselves or others, appropriateness for commitment, decisional capacity, disability, and competency” (Ref. 82, p 29). Unfortunately, these requirements leave out correctional psychiatry.³⁹ To better address the mental health needs of justice-involved populations, multiple scholars have called for expanding, or even requiring, training experiences for mental health professionals in correctional settings.^{7,39,70,72,83,84}

Not all MHPs will decide that correctional psychiatry is the right fit for them. Even when MHPs decide to work in the field, correctional facilities still grapple with clinician turnover and the difficulties of retaining qualified staff.^{3,85} Working in correctional settings can be stressful^{85,86}; identifying ways to improve the quality of life for MHPs in these roles and to retain them in existing positions could also alleviate shortages in correctional psychiatry.

A 1961 article noted that “psychiatry brings to corrections the great traditions of medicine” (Ref. 87, p 18). Combating misconceptions about correctional psychiatry might help convince more MHPs of this truth.

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