CHAPTER 71

The Future of Correctional Psychiatry
Evolving and Recommended Standards

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Introduction

Although recent decades have seen many advances in the knowledge base and practice standards for correctional psychiatry, in many ways the field remains in the early stages of development. As it continues to mature in the coming years, we hope and expect to see further progress. Establishment of evidence-based clinical practices and a firm foundation for ethical standards has begun, and the momentum will continue to build. In this chapter we discuss opportunities to expand the evidence base of correctional psychiatry, the need to refine practice guidelines, and the role that psychiatry might play in influencing the use of incarceration. As part of our review, we describe what we believe the future may hold for our subspecialty.

Where things stand

The broad range of topics covered in this textbook attests to the growing complexity of the field of correctional psychiatry. As reflected in some of the chapters, correctional psychiatry has areas that lack consensus or a well-established evidence base. Existing guidelines and standards do not fully address many significant clinical and ethical dilemmas that face practitioners. Professional psychiatric associations and correctional accreditation agencies have given scant attention to some of these issues or do not adequately monitor and enforce some standards that do exist.

These deficiencies take on greater significance given the prevalence of psychiatric disorders among inmates. Many individuals with the most serious mental illnesses reside in jails and prisons. The psychiatric profession would be remiss if it did not attend to their needs. Our professional organizations must promulgate clear ethical and clinical standards that support correctional practitioners. Anything short of this evades our collective responsibilities.

Relatively little research has been done in correctional psychiatry compared to other areas of psychiatric practice (Cislo & Trestman, 2013). Some of that research has relied on community-based tools and methods that do not necessarily adapt well to jail- and prison-based studies. For example, much of the basic epidemiologic data on the prevalence of mental illnesses among inmates has used screening instruments developed for use with community populations. Symptoms and behaviors (e.g., hypervigilance, anxiety, aggression) suggestive of pathology using these instruments can represent normal and adaptive findings among individuals in jails and prisons. These and other limitations have led many correctional mental health researchers to conclude that we need to greatly expand the empirical foundation of the field (Appelbaum, 2008). Chapter 70 reviews the history, challenges, and potential for correctional research in more depth.

In addition to the need for targeted research, correctional facilities differ from community settings in the opportunities they present for assessment and intervention. Incarceration, for example, enables unusually close monitoring of patients receiving an outpatient level of psychiatric care. This allows psychiatrists to more safely take a bolder approach to therapeutic trials while patients are on or off of medications. Chapters 19 and 20 discuss these opportunities for pragmatic management and diagnostic review.

Untapped prospects for innovation in assessment and intervention abound in correctional psychiatry. We also need to better understand the things we already do. For example, different models of behavioral intervention programs exist, but we lack robust findings that allow us to differentiate which programs work best for specific populations of inmates. A consensus has emerged about specific standards for some interventions (e.g., number of hours per week for out-of-cell structured and unstructured activities for inmates with mental illness in lockdown settings). These standards, however, often lack an empirical foundation. The recommended programming levels for inmates in segregation, for example, have arisen largely from a cascade of imitative court decisions without data to support their specificity. We also need to understand whether the efficacy of standard community clinical practices differs when used with inmates.

The future of correctional psychiatric practice and standards

At the most basic level, correctional psychiatrists must grapple with several questions. First, should clinical and ethical standards
differ in correctional settings compared to other practice venues? Any substantial divergence in such standards requires thoughtful and thorough consideration of the implications. Second, if disparate standards are warranted, how will we establish those standards? Our professional organizations will need to devote similar attention to developing and promulgating such standards as they have to dissemination of guidelines for practice in noncorrectional settings. Third, how will our profession support correctional practitioners who find themselves under pressure to act in ways inconsistent with clinical and ethical standards? The following discussion illustrates some of the challenges we face as we try to answer these questions.

Do standards differ?

Before considering whether psychiatric practice in correctional settings should have unique clinical and ethical standards, we should first determine whether differences already exist between community and correctional activities. In what ways, if any, does our work in jails and prisons actually vary from what we do in other settings, or at least come under pressure to diverge from community-based customs? Several examples come to mind.

Confidentiality is an essential condition for psychiatric care. It is akin to creating a sterile field in surgery. It may yield under emergency circumstances but remains a prerequisite at all other times. Frequent exceptions to privacy, however, occur in some correctional settings, especially segregation or lockdown units. Routine cell-front clinical encounters breach confidentiality in a way that would never be tolerated outside of correctional facilities.

Pharmacological practices in correctional settings also tend to stray from community standards. Significant, and understandable, concerns arise about prescription of controlled substances to inmates (Burns, 2009). Many of those concerns, however, have parallels to risks associated with controlled substances for patients in the community. Nevertheless, correctional formularies often include de facto exclusions that rarely have counterparts in community medication access.

Inmates sometimes need clinical restraints, if not seclusion (Metzger, Tardiff, Lion, et al., 2007). Jails and prisons, however, are more like community outpatient settings than inpatient units. Jails, prisons, and community outpatient settings generally lack the staffing and therapeutic environments to provide seclusion or restraint in a way consistent with prevailing standards. Outpatients who need such emergency interventions typically are admitted for hospital care; however, the same does not always occur for inmates who may have clinical restraints applied in minimally therapeutic environments and with reduced procedural protections (Appelbaum, 2007).

Stigma remains an issue for psychiatric conditions in general, but more so for some disorders than others. The nature of gender dysphoria and its treatment, for example, may be difficult for many individuals, including custody officials and some mental health professionals, to grasp and accept. Correctional psychiatrists may come under pressure to endorse denials of services for individual inmates or specific disorders in general. Such pressure can place psychiatrists in conflict with prevailing clinical standards in psychiatry and in medicine in general that explicitly support access to care (American Medical Association, 2008; American Psychiatric Association, 2012).

In relation to ethical standards and practices, correctional psychiatrists are asked to do things that have no parallel in community settings. Along with other mental health staff, they may be asked to evaluate inmates prior to or while being housed in segregation for psychiatric contraindications to such placement. A growing international consensus, however, has called for the abolition of or significant restrictions on the use of solitary confinement, sometimes describing the use of isolation for periods exceeding several weeks as akin to torture (Gibbons & Katzenbach, 2006; Godinez-Cruz v. Honduras, 1989; Mendes, 2012; New York Times, 2011). In many instances, placement in segregation has an explicitly punitive purpose. Assessing the mental stability of individuals to tolerate punishment under conditions of intentionally unpleasant and stressful deprivations, and subsequently providing clinical clearances to place them under such conditions, let alone participation in torture, has no equivalent in community practice.

Similar concerns arise with inmates on hunger strikes. Some custody-initiated standards equate hunger strikes with other situations that threaten institutional security . . . [such as] riots . . . disturbances, and taking of hostages” and call for involvement by medical personnel in formulation of the plans to respond to these events (American Correctional Association, 2003). If those plans include forced feedings for inmates who rationally and voluntarily refuse nourishment, the psychiatrist engages in an intervention that would not be sanctioned in the community and violates internationally accepted ethical norms for interactions with inmates (World Medical Association, 1975).

As the previous discussion indicates, some fundamental differences do exist between current correctional and community-based psychiatric practice. Are they warranted?

Should clinical and ethical standards differ in correctional settings?

Jails and prisons are unique environments. For example, inmates have been charged with crimes or adjudicated guilty of those crimes, and the institutional mission includes containment and public safety. Do such differences warrant clinical and ethical standards for psychiatric practice that diverge from community standards? If the correctional mission were exclusive, or even just paramount, that might sway the answer. Medical and psychiatric care for inmates, however, plays as integral a role in correctional policy and procedure as do other considerations. The US Supreme Court has recognized a constitutional mandate for clinical services (Estelle v. Gamble, 1976). The right to psychiatric care is fundamental, not ancillary. This suggests that justifications, if any, for divergent standards of care must be compelling.

A need exists for correctional psychiatrists, and the psychiatric profession in general, to closely examine current disparities in practice. Convenience or resource constraints provide a poor basis for disparity. Transferring inmates from segregation cells to private interview rooms, for example, requires available space and takes time and staff. Other needs compete for those resources, but confidentiality is a core component of psychiatric care and failure to provide it falls below acceptable professional, if not constitutional, standards. Comparable considerations have relevance to an analysis of clinical procedures for seclusion, restraint, or other practices.

Public safety and security considerations may also have relevance to clinical services such as treatments for gender dysphoria
or availability of medications for psychiatric disorders. Potential compromises to safety and security cannot be ignored. They must be balanced, however, with the clinical consequences of a lowered standard of care. As with the issues discussed above, resource limitations provide poor justification for clinical restrictions that result in substandard care. Reasonable adaptations other than clinical restrictions (e.g., providing settings where transgendered inmates can safely receive treatment, ensuring sufficient numbers of custody staff to transfer inmates to confidential rooms for clinical encounters) require full implementation before considering the balance between clinical and security needs.

Where and how to draw an ethical line poses especially thorny challenges. Correctional systems in the United States do not always follow the most progressive inmate management practices. Individual psychiatrists may balk at working in settings they consider draconian. It would be an extreme and unnecessary reaction, however, for the profession as a whole to withdraw from serving the inmate population. One can do good work even in faulty settings. If psychiatrists, however, are required to play a role in punitive or psychologically harmful correctional practices, a thoughtful review becomes necessary. Whether these practices ultimately advance security or other penological interests is a question for custody officials to grapple with. However, even if punishment serves legitimate correctional purposes, participation by psychiatrists may not be appropriate. Does it make a difference that segregation evaluations screen some fragile inmates out of that placement when the evaluations screen other inmates in? Does it matter that some inmates tolerate prolonged segregation without showing signs of significant distress or lasting psychological harm? If ongoing monitoring of inmates in segregation can identify and remove those who begin to show significant distress, does this lessen ethical concerns about providing mental health clearances for placement in these units?

If disparate standards are warranted, how will we establish them?

An infrastructure already exists for consideration of correctional psychiatry guidelines and practice standards, but extant resources have their limitations. The American Psychiatric Association's Task Force Report on Psychiatric Services in Jails and Prisons (2000) provides mostly general principles, but they do assume compliance with the National Commission on Correctional Health Care (NCCHC)'s Standards for Mental Health Services in Correctional Facilities (2008), which has more targeted and specific standards. Neither, however, tackles in detail the type of challenging questions identified above.

NCCHC Standard MH-A-09 states that "mental health services are conducted in private" but considers this only an "important," not an "essential," standard. Essential standards represent "the critical components of a mental health care system" (Appendix H), taken into account for NCCHC facility accreditation. Thus, the lack of privacy for clinical encounters would not necessarily impede accreditation.

The American Psychiatric Association's report states that "The fundamental policy goal for correctional mental health care is to provide the same level of mental health services to each patient in the criminal justice process that should be available in the community" and that "a full range of psychotropic medications, including involuntary medication, must be available" (Sections II.B and III.B). The NCCHC has more general essential requirements that "inmates have access to care to meet their serious mental health needs" (MH-A-01) and that "custody and administrative staff support and do not interfere with the implementation of clinical decisions" (MH-A-03). Taken collectively, these standards could be read as providing support for inmate access to controlled substances, treatment for gender dysphoria, and other interventions that correctional psychiatrists deem clinically indicated. This does not always happen in actual practice, however.

The American Psychiatric Association's report gives tacit approval to segregation clearances when it calls for "regular rounds by a qualified mental health clinician in all segregation housing areas...in order to identify any inmate who appears to be showing signs of mental deterioration or psychological problems." NCCHC standards do the same by stating "mental health staff reviews...to determine whether existing mental health needs contraindicate the placement or require accommodation" (MH-E-07). Although these positions might reflect an underlying consideration of and comfort with the ethics of this role, it may instead reflect only an acceptance of the prevailing use of segregation in prisons and jails. In contrast to these stances, the American Psychological Association adopted a resolution in 2008 setting "an absolute prohibition against the following techniques...isolation; sensory deprivation and over-stimulation;...or the threatened use of any of the above techniques" and stating that "psychologists are absolutely prohibited from knowingly planning, designing, participating in or assisting in the use of all condemned techniques at any time" (American Psychological Association, 2008).

Organizations such as the American Psychiatric Association and NCCHC that have a vested interest in correctional psychiatric standards need to clarify, refine, and expand their positions in a way that offers explicit guidance and support to practitioners and correctional programs. The development, review, and promulgation of professional guidelines take time and effort to do well. Reaching consensus is not always easy, but further maturation of the field of correctional psychiatry requires this of us.

How will our profession support correctional practitioners who act in ways consistent with clinical and ethical standards?

Many correctional psychiatrists work in settings where they have no on-site peer support. They might find allies among medical colleagues and mental health professionals from other disciplines, but they often provide the sole voice on clinical and ethical standards for their own practice. Pressure from custody staff and other clinicians to bend, if not break, those standards sometimes becomes intense. This underscores the need for explicit professional guidelines that directly address the situations that correctional psychiatrists often face, such as the use of restraint and seclusion (Metzner et al., 2007). Those guidelines provide practitioners with defensible, sound, nonidiosyncratic bases for their positions if challenged.

Professional organizations can also play a more proactive role. Many of our patients who are most in need of treatment have become incarcerated. We need to have a strong voice on their behalf. This might entail outreach and advocacy efforts by professional societies, such as supporting psychiatrists in jails and prisons in their efforts to explain professional standards to correctional administrators. It may also include more formal review and commentary on policies and practices in local and national settings.
The potential role in the future use of incarceration

have considered the potential evolution of clinical and ethical standards of psychiatric practice with inmates. Might psychiatrists have something to offer to efforts to reform the nature of incarceration itself? Thoughtful but mostly abortive attempts to do this have been made in the not-so-distant past (Menninger, 1970). More recently, burgeoning rates and costs of incarceration, at least in the United States, have created fertile ground for a new wave of reforms. 

In the absence of psychiatric input, alternatives-to-incarceration programs will likely expand. Management of many violent criminals or those with only substance use–related problems may shift to community settings. Psychiatrists can play a significant role in designing and implementing interventions for such populations.

As an alternative to incarceration for less serious offenders, it is recommended that a greater percentage of people who are incarcerated will have aggressive behaviors. As currently constituted, some of these inmates will have underlying mental disorders that contribute to their challenging behaviors. Thus, the problems of jail and prison inmates who need psychiatric services increase, enhancing the central role that psychiatrists and mental health professionals already have in these facilities.

With treating high rates of mental illness among incarcerated individuals, psychiatrists may have contributions to make toward mitigating violent tendencies among inmates. This might involve development and expansion of behavioral programs that teach skills to manage emotions and avoid violence. A discharged back to the community. On a more fundamental level, psychiatric insights could help correctional administrators identify some punitive and security-based policies and practices that may reduce the risk of future inappropriate behaviors and even exacerbate that risk (e.g., excessive use of segregation).

Finally, in countries that have or adopt a one-payer system of health care or those that have multiple but well-integrated systems, inclusion of seamless coverage for inmates would allow for better coordination and continuity of care across community mental health settings. A well-functioning national medical records system would add to efficiency in care. The time might also come when inmates have routine access to a comprehensive range of health services (e.g., for treatment of sick call requests or for psychoeducational materials). Opportunities such as these would open expanded opportunities for psychiatrists to provide services to criminal justice populations that rival the best available community services and meet highest standards of care.

Summary

The questions and dilemmas that we have presented do not all lend themselves to easy consensus. They do, however, require attention and resolution. Custodial and clinical practices in correctional settings continue to evolve and change. Some of these changes occur in a rapid and dramatic way. Psychiatry should take a place in the forefront of the ongoing debate. By being proactive instead of reactive, we will have a greater chance of influencing the outcomes and we will fulfill our responsibilities for the patients we serve. No one can predict with certainty what the future holds. We feel safe, however, in predicting that incremental and perhaps revolutionary changes will occur. We hope that this textbook contributes to a picture of where things stand and a vision of where we need to go.

References


American Psychological Association (2008). Restatement of the American Psychological Association position against torture and other cruel, inhuman, or degrading treatment or punishment and its application to individuals defined in the United States Code as "enemy combatants." Available at: http://apa.org/about/policy/torture.aspx


