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# Why It's So Impossible to Get Decent Mental Health Care in Prison

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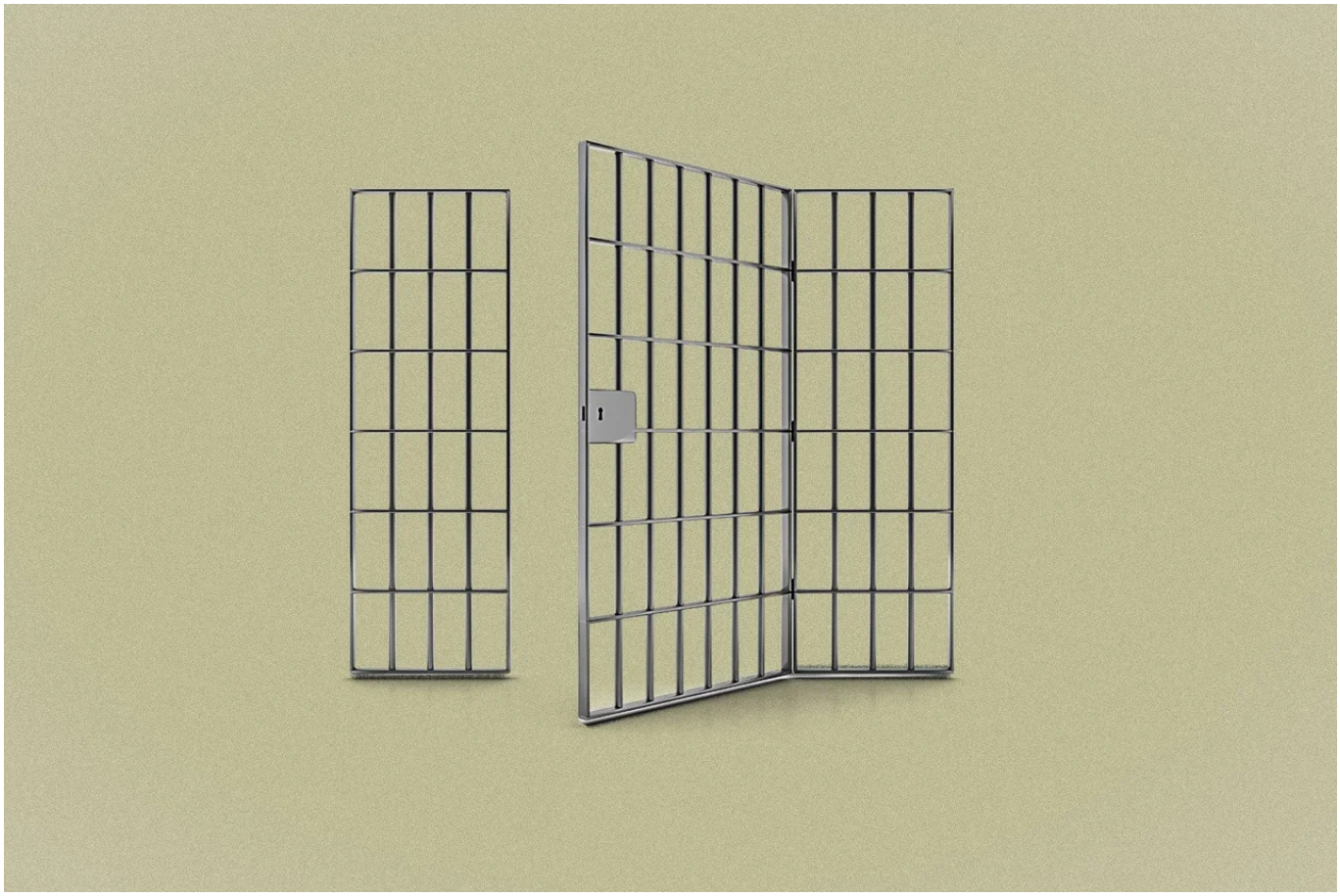

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*Welcome to State of Mind, a new section from Slate and Arizona State University dedicated to exploring mental health. Follow us on Twitter.*

Massachusetts' Norfolk Prison Colony was a bold experiment when it opened in 1928. The facility looked like a conventional prison, but reformers were excited by its innovative staffing model. Unlike other prisons, Norfolk was to have two completely separate sets of employees. The watch officers were to patrol the high wall that ringed Norfolk; they would have no contact with the hundreds of prisoners unless someone flagrantly broke the rules.

The house officers were to develop relationships with the prisoners, counsel them, and prepare them for freedom.

Howard Gill, Norfolk's visionary and warden, devised the staffing system to overcome the traditional hostility between guards and prisoners, which made rehabilitation impossible. By placing the watch officers at the wall and creating a new, friendly type of employee, Norfolk was to have both security and treatment.

But soon after opening, the watch officers and house officers were at loggerheads. The watch officers confiscated prisoners' possessions that the house officers had approved. They locked doors that were supposed to stay open. Each staff believed the other was sabotaging Norfolk. By 1932, the watch officers' interests decisively won out—security was paramount.
Norfolk quickly became a conventional prison. The lesson:

"Guards and would-be social workers could not coexist in the same institution," David Rothman wrote in *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America*. "Norfolk … reveals the difficulty, even the impossibility, of a program that would at once cure and coerce, that would discipline and rehabilitate."

Howard Gill's experiment failed. But today, prisons are still trying to bring his vision to life: to resolve the fundamental tension between security and rehabilitation. In particular, society tasks prisons with the treatment of prisoners with mental illnesses—to simultaneously heal them and punish them. It's still not working.

The Illinois Department of Corrections, for example, has been under an injunction from a federal court since 2018 for failing to provide adequate mental health care. In summer 2021, amid ongoing judicial scrutiny, a report found that Illinois prisons call it "treatment" when a mental health care worker walks through the corridor of a solitary confinement wing and speaks to prisoners through their cell doors. Mentally ill prisoners in solitary are also allotted one 15- to 30-minute session with a mental health care worker every 30-60 days.

In 2015, Oregon's prison system was locking mentally ill prisoners in their cells for 23 hours a day. In January 2021, after investigations and outside intervention, a report found that Oregon still locked some mentally ill prisoners alone in their cells for 21 hours a day. That's just shy of the U.N.'s definition of torture, which is 22 hours a day of solitary confinement.

Prison systems are not uniformly brutal. There are cases where mentally ill prisoners receive useful treatment. A recent literature review found that mindfulness-based

therapies have helped prisoners with depression and anxiety, and pharmaceutical drugs can also improve mentally ill prisoners' well-being, at least compared to incarceration without any psychological treatment at all. In the U.K., some prisoners get useful care—in one survey, 54 percent of incarcerated women with a mental illness said they got help at their current prison. But a recent government report found that only 10 percent of prisoners in the U.K. receive mental health care treatment, whereas almost 70 percent are suffering from a mental illness.

Prison, as a rule, harms incarcerated people's mental health. Prisoners are separated from their loved ones. They have no privacy. There is constant noise. They are frequently assaulted by fellow prisoners and staff. They have no control over their lives. Many people in prison were already mentally ill before their incarceration, but the experience tends to worsen their preexisting conditions and saddle them with new ones. Research has found that incarceration ratchets up a person's odds of developing post-traumatic stress disorder, bipolar disorder, and major depression.

Ironically, prisoners are theoretically well-placed to receive mental health care. Many incarcerated people were too poor to access care when they were free, but they have a legal right to it while they're a ward of the state. Scholars have argued that prisons are an "opportunity" to provide health care to people who wouldn't otherwise get it, and some prisoners get a diagnosis and a prescription for the first time behind bars.

But prisoners face fundamental barriers to adequate care. For starters, there's a longstanding political principle that prisoners' living conditions should be no better than those of the poorest free people—anything more would turn society on its head, incentivizing people to get locked up. Given that many free people can't obtain the care they need, prisoners seldom get quality treatment. In Texas, for example, prisoners with cancer survive less than half as long as demographically similar sick people on the outside.

Even when prisoners receive care, they're always prisoners first and patients second. Mental health care workers have "dual loyalty" to their patients and the prison itself, which means they're sometimes obliged to betray their patients' interests. For example, if a patient discloses suicidal thoughts to a mental health care worker, the worker may, even over the objections of their patient, inform the guards, subjecting their patient to the trauma of a strip search and placement in a solitary cell under surveillance. Anything prisoners say could be used against them in front of a parole board, which further deters them from being honest with mental health care workers, impeding treatment.

"Psychotherapy in prisons does not and cannot work," wrote Stephen Schlesinger, a psychologist who was a consultant for a prison, in a 1979 paper.

Despite the low quality of care, the mental health care system is still a precious resource behind bars. Prisoners who aren't mentally ill sometimes try to exploit the system to cope with the pains of imprisonment . Malingering is fairly common—studies estimate that between 10 and 25 percent of male prisoners seeking psychological treatment invent symptoms. Some pretend to hear voices, for example, in order to get medication to numb themselves, or to sell or trade it. In other cases, prisoners malinger to try to get themselves out of solitary confinement, or a transfer into a quieter mental health-centered unit. Mental health care resources, in other words, can soften a prisoners' punishment.

This implicates mental health care workers in the maintenance of a prison's punitive integrity. Doctors also gatekeep medications in the free world, but prison is a different matter. If they take prisoners at their word, they could send contraband drugs flowing through the prison. Scarce beds for treatment could go to the wrong people. Misbehaving prisoners could weasel out of punitive solitary confinement.

"If the doctors who are involved just give in … then it makes it harder for the prison staff 'cos [the prisoner] goes back and tells the wing that Dr X is a walkover and then they are all coming over," said a psychiatrist working in a prison in the U.K., quoted in a 2009 paper. "They sell it for 'gear' to other prisoners and it makes a breakdown of the system more likely."

But guarding health care can inure staffers to prisoners' suffering. Legitimately mentally ill prisoners get tagged as malingerers and deprived of care. Suicide attempts are explained away as efforts to manipulate staff. In the worst cases, even health care itself is sometimes repurposed for security: Mental health care workers have a history of using drugs to pacify and control prisoners. Overprescribing antipsychotics can keep prisoners orderly, if not healthy.

Prison systems also deliberately blur the line between the health care and security staffs. Mental health care workers sign off on prisoners' punishments. Guards often distribute prisoners' medications. Health care workers in prisons are always "professional law enforcement officers first," as the Federal Bureau of Prisons told the Marshall Project—security comes before health in their job description.

Prisons have finally solved the Norfolk problem. Guards punish prisoners and doctors also punish prisoners. The house officers and the watch officers united at last.

*State of Mind is a partnership of Slate and Arizona State University that offers a practical look at our mental health system—and how to make it better.*

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