Finding a Voice

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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 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?

Unable to resolve these moral dilemmas, I followed my patients into the world of outpatient mental health, becoming the chief medical officer at a New York City community organization dedicated to providing care to individuals affected by the criminal legal system. Given my past experiences, I arrived with a more focused awareness of the devastating effects of arrest, incarceration, forced hospitalization, poverty, and racism. Although I encounter daily the feelings of helplessness that I feared years ago when I first thought about leaving the hospital and jail, I am now even more deeply invested in the patient advocacy that was born within those same institutions. When I get a discharge summary from the New York prison system describing a 40-year-old Black man on high doses of antipsychotics, I know that my assessment of him will likely include a conversation about solitary confinement and survival and that my treatment may involve removing an inappropriate diagnosis, gradually tapering off his medications, and helping him find again—or for the first time—his independent and powerful voice.

Now, when I talk to medical students and residents, I have the perspective of someone who has ventured into the secret spaces where society puts the people we fear. As 2020 came to a close, I realized that my search for the root causes of my patients' trauma in the jail system did not lead me to some hidden horror behind those bars. It led me back out into the free world where "Not in my backyard" is the rallying cry of a country that prefers to whitewash our racist and classist identity. A world where a 70-year-old Brown man who is homeless, is on lifetime parole, and has severe PTSD risks reincarceration by jumping the subway turnstile just to get to his appointment with me. A world where a 24-year-old Black man tells me that he missed his appointment at another clinic because of a delay in his release from jail and is told that, since he is therefore undependable, he cannot have another appointment for 6 weeks.

It is only through experience and curiosity, and sometimes in spite of the advice of my colleagues, that I have become comfortable treating and being inspired by people with whom I initially thought I shared so little. I was taught in medical school and residency, even if not explicitly, to see deficiency and pathology in those who live through incarceration. Instead, I have learned to see resilience and hope.

I believe that the only way to truly transform the criminal legal system is to match intense and effective public activism with an understanding of the deep forces at play within courtrooms and correctional facilities. There need to be voices who scream from the inside, who work to alleviate suffering in the spaces that cause suffering, and who bear witness to the displays of human cruelty and neglect that institutions of confinement can create. Psychiatrists can and should represent more of those voices. A brilliant psychologist once told me that, in places where respect for humanity can be crushed from all sides, caring is not enough. For mental health professionals, empathy and sensitivity are necessary but not sufficient; one needs also to use clinical skills and advocacy to make lasting change. What is the additional purpose of bearing witness if not to speak the truth and try to effect that change?

The Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education, organizations responsible for the training of medical students and psychiatric residents, have never required that trainees gain clinical experience in a jail or a prison (5, 6). There has never been a time when there were enough psychiatrists to meet the critical needs of people who are incarcerated. There is no professional organization that has meaningfully devoted itself to supporting the "justice" psychiatrists who seek to reduce the harms of incarceration from both inside and out. These limitations ensure that psychiatrists will continue to be poorly equipped to care for the millions of people who have been traumatized by incarceration and that organized psychiatry can continue to remain distant from its enmeshment in our oppressive and racist criminal legal system.

There is a path to a more just and equitable criminal legal system that is dramatically different from the one in place now. However, until psychiatry as a field encourages and supports professional exposure to the jails and prisons that so deeply affect and burden many of our patients' lives, we will not be on that path, and our voices will go unheard.

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