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Carceral Psychiatry and the Path to Decarceration: A Critical Review of Mental Health in Prisons

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Abstract

The overrepresentation of people with mental illnesses in prison systems worldwide constitutes a public health crisis and a failure of community psychiatry. This paper provides a comprehensive, critical synthesis of research at the intersection of mental health, prisons, and psychiatry. It first establishes the epidemiology of psychiatric disorders among incarcerated populations, then traces the historical path from asylum to prison, a phenomenon termed transinstitutionalization. Next, it examines the iatrogenic effects of incarceration on mental health, including solitary confinement, violence, and inadequate treatment. The paper then analyzes current psychiatric care within prisons, screening, medication, therapy, and crisis intervention, highlighting systemic barriers to quality care. The principle investigator (PI) explores the overuse of psychotropic medications and the ethical quagmire of coercive treatment. Finally, the paper proposes evidence-based reforms: diversion programs, specialized mental health courts, prison-based therapeutic communities, and reentry support. The paper also argues that meaningful reform requires dismantling carceral logics within psychiatry and investing in community alternatives. This review aims to guide researchers, clinicians, and policymakers toward a just and effective mental health system.

Keywords: Prison Psychiatry, Mental Health, Incarceration, Transinstitutionalization, Solitary Confinement, Mental Health Courts, Forensic Psychiatry, Carceral System

1. Introduction

The prison has become the de facto psychiatric institution of the 21st century. In the United States, jails and prisons now hold approximately ten times more people with serious mental illness than all state psychiatric hospitals combined [1,2]. This shocking reversal, from asylum to cell, represents one of the most consequential and tragic transformations in modern mental health policy. It is not an accident of history but rather the predictable outcome of decades of policy choices, budgetary priorities, and cultural attitudes toward both mental illness and punishment. Individuals with schizophrenia, bipolar disorder, major depression, and post-traumatic stress disorder (PTSD) now cycle through correctional facilities at rates that vastly exceed those found in the general population [3,4]. For many, incarceration has replaced hospitalization as the primary institutional response to psychiatric crisis. Why has psychiatry failed to prevent this mass incarceration of the mentally ill? The answer lies in a confluence of interrelated forces: the poorly planned deinstitutionalization of the mid 20th century, the chronic and severe underfunding of community based mental health services, the expansion of punitive drug policies, and the routine criminalization of nonviolent behaviors that are driven directly by untreated psychiatric symptoms [5,6]. Rather than receiving care in clinics or crisis stabilization units, individuals experiencing hallucinations, mania, or severe depression are often arrested for disorderly conduct, trespassing, or petty theft. Once inside, the prison environment does not simply house people with pre existing conditions, it actively exacerbates those conditions and iatrogenically creates new ones. Suicide, self harm, and a constellation of symptoms now termed post incarceration syndrome have become endemic [7,8].

This paper provides a rigorous yet accessible synthesis of the available evidence. The PI begins in Section 2 by detailing the prevalence of psychiatric disorders among incarcerated populations, emphasizing differences by gender, age, and geographic region. Section 3 traces the historical trajectory from asylum to prison, focusing on deinstitutionalization and the Penrose Hypothesis. Section 4 explores the specific mechanisms through which incarceration harms mental health, including solitary confinement, violence, and environmental stressors. Section 5 offers a critical appraisal of current psychiatric practices within carceral settings, from intake screening to medication management and suicide

prevention. Section 6 outlines the profound ethical dilemmas faced by psychiatrists who work in prisons, including dual loyalty and coercive treatment. Section 7 presents evidence based reform strategies that have been shown to reduce harm and improve outcomes. Finally, Section 8 concludes with a set of concrete policy imperatives. The overarching thesis is that prison psychiatry, as currently practiced in most jurisdictions, often serves to manage and control rather than to treat and heal, and that truly meaningful reform requires decarceration and a robust reinvestment in community based care.

1.1. Epidemiology of Mental Illness in Prison Populations

Globally, the prevalence of mental disorders is substantially higher among incarcerated individuals than among the general population. This consistent finding holds across diverse legal systems, cultural contexts, and economic conditions. A landmark systematic review and meta analysis by synthesized data from 24 countries and found that 3.7% of male prisoners and 4.0% of female prisoners have psychotic disorders, rates approximately four to five times higher than those observed in the community [3]. For depressive disorders, the numbers are even more striking: major depression affects 11.4% of incarcerated men and 30% of incarcerated women [9]. These figures far exceed the 12 month prevalence of approximately 6–7% for men and 10% for women in community samples, indicating that prisons have effectively become primary sites of mental health burden. Post traumatic stress disorder (PTSD) is similarly overrepresented. Rates range from 10% to 30% across studies, reflecting the high prevalence of prior trauma and victimization, including childhood physical and sexual abuse, intimate partner violence, and exposure to community violence, among individuals who end up in the criminal legal system [10,11]. Importantly, these rates are likely underestimates, as many prisoners are reluctant to disclose trauma histories due to stigma, fear of appearing vulnerable, or distrust of institutional providers. Women in prison exhibit even higher rates of psychiatric morbidity than men. Between 60% and 80% of incarcerated women meet criteria for at least one mental disorder, often with co occurring substance use disorders and extensive histories of physical or sexual abuse [12].

This pattern has been described as a "trauma to prison pipeline," in which untreated trauma symptoms lead to substance use, survival behaviors, and eventual arrest. In juvenile detention, the prevalence of conduct disorder, attention deficit/hyperactivity disorder (ADHD), and major depression is three to ten times higher than in community samples of adolescents [13,14]. Many of these young people have never received any form of mental health treatment prior to incarceration. Suicide is the leading cause of death in many jails, with rates three to eight times higher than in the general population [15]. The risk is highest during the first 24 hours of incarceration, a period of acute disorientation, fear, withdrawal from substances, and often insufficient medical or psychiatric screening [16]. Suicide in prison is not merely a clinical tragedy; it is frequently a systems failure, reflecting gaps in screening, observation, environmental safety, and access to crisis care. Notably, these epidemiological findings are not uniform across all nations. Nordic countries, which maintain more robust welfare systems, smaller prison populations, and stronger community mental health infrastructure, show lower rates of serious mental illness in prisons than the United States or the United Kingdom, though rates remain elevated compared to community samples [17,18]. This cross national variability underscores a critical point: the overrepresentation of mental illness in prisons is not inevitable. It is shaped by social policy, health system design, and the extent to which communities provide alternatives to incarceration.

1.2. Historical Origins: From Asylum to Prison

The current crisis has deep historical roots that cannot be understood without examining the mid 20th century policy of deinstitutionalization. Beginning in the 1950s and accelerating through the 1980s, deinstitutionalization closed hundreds of large state psychiatric hospitals in the United States and similar institutions across Europe [19,20]. The movement was initially laudable in its goals: to liberate patients from overcrowded, understaffed, and often abusive asylums; to replace long term custodial care with community based treatment; and to restore the civil rights of people with mental illness. However, the promised community based alternatives, supported housing, intensive case management, crisis stabilization units, and vocational programs, never materialized at the scale required. Funding never fully followed patients from the state hospital budgets into community mental health systems [21,22]. As a result, hundreds of thousands of individuals with serious mental illness were discharged into communities with few services, no affordable housing, and little social support. Simultaneously, the War on Drugs and the implementation of mandatory sentencing laws dramatically expanded prison populations in the United States. Incarceration rates rose from approximately 200,000 in the early 1970s to over 2 million by the year 2000 [23,24].

This expansion disproportionately affected people with mental illness. Individuals with untreated psychotic or mood disorders, often exhibiting disruptive or bizarre behaviors, were arrested for low level, nonviolent misdemeanors such as trespassing, disorderly conduct, shoplifting, or petty theft, crimes of survival, not malevolence [25]. In the absence of accessible psychiatric beds or crisis services, police officers and judges increasingly turned to jails and prisons as the only available institutions capable of confining people in distress. As early as 1939, the British psychiatrist Lionel Penrose observed an inverse relationship between the number of psychiatric hospital beds and the number of prison beds across European countries. This relationship, later termed the Penrose Hypothesis, suggested that reducing mental health institutional capacity without adequate substitution leads directly to increased criminal justice involvement for people with mental illness. Modern research confirms this "transinstitutionalization": as psychiatric beds decreased, prison populations grew, specifically among those with

mental disorders [26,27]. By 2014, the three largest psychiatric facilities in the United States were not hospitals but jails: the Los Angeles County Jail, Cook County Jail in Illinois, and Rikers Island in New York [1]. This transformation reflects not inevitable social progress but rather a series of deliberate policy failures, in which the moral commitment to community integration was never matched by financial or structural support.

1.3. Iatrogenic Harms of Incarceration on Mental Health

Imprisonment is not merely a neutral container for pre existing illness; it actively worsens mental health and creates new psychological pathology. The prison environment is inherently stressful, restrictive, and often traumatic. Coined the term "prisonization" to describe the process by which prisoners adapt to the carceral environment by adopting hypervigilance, emotional suppression, distrust of others, and a chronic expectation of danger [7,28]. He later developed the concept of "post incarceration syndrome" to capture the lasting psychological sequelae of prolonged confinement, including social withdrawal, compulsive security checking behaviors, emotional numbing, and difficulty re establishing trusting relationships after release.

1.3.1. Solitary Confinement

Perhaps no single practice is more damaging to mental health than solitary confinement (also called restrictive housing, segregation, or the "hole"). Even relatively brief periods of 10–15 days produce measurable increases in anxiety, panic attacks, paranoia, auditory hallucinations, suicidal ideation, and perceptual distortions [8,29]. Prolonged solitary confinement, lasting months or years, can induce a state resembling psychosis, with disorganized thinking, persecutory delusions, and profound emotional deterioration. In a large longitudinal study of incarcerated men in New York state, placement in solitary confinement was associated with a 78% increase in self harm incidents and a 6.9 fold increase in suicide attempts [8]. People with serious mental illness are disproportionately placed in solitary confinement despite clear evidence that they are the least able to tolerate it. International human rights bodies, including the UN General Assembly, have condemned prolonged solitary confinement as a form of cruel, inhuman, or degrading treatment, yet the practice remains widespread in many correctional systems [30].

1.3.2. Violence, Victimization, and Trauma

Prison violence is endemic. Physical assault, sexual victimization, and the chronic witnessing of violence against others are everyday realities in many correctional facilities. These experiences routinely lead to PTSD, complex trauma, and exacerbation of pre existing mood and anxiety disorders [31]. Individuals with mental illness are twice as likely to be victimized as other prisoners, precisely because their symptoms, such as unusual behavior, poor social judgment, or difficulty recognizing danger, make them more visible and vulnerable targets [32]. This victimization, in turn, worsens psychiatric symptoms, leading to a vicious cycle of decompensation, behavioral infractions, further segregation, and re victimization.

1.3.3. Environmental Stressors

Beyond overt violence, the ordinary environmental conditions of many prisons degrade mental health. Overcrowding, constant noise, limited access to natural light, poor nutrition, lack of privacy, and enforced idleness all contribute to elevated rates of depression, anxiety, and irritability [9,33]. The absence of meaningful activity, work, education, recreation, or creative expression, amplifies feelings of hopelessness, worthlessness, and loss of purpose. Sleep deprivation is routine in prisons, due to noise, lighting schedules, cell checks, and the hypervigilance that confinement induces; chronic sleep disruption is known to exacerbate mood instability, cognitive dysfunction, and psychosis [34]. Taken together, these iatrogenic harms mean that incarceration often leaves people with worse mental health than when they entered, undermining any purported public safety or rehabilitative goals.

1.4. Psychiatric Care Inside Prisons: Current Practices and Barriers

Despite legal mandates, including the landmark U.S. Supreme Court decision Estelle v. Gamble, which established a constitutional right to health care for prisoners, psychiatric care in carceral settings is often deficient, fragmented, and coercive [35]. The gap between legal standards and on the ground reality is vast.

1.4.1. Screening and Intake

Many facilities fail to conduct adequate mental health screening within the first hours of admission, missing critical opportunities to stabilize acutely ill individuals and prevent suicide [36,37]. Common screening tools, such as the Brief Jail Mental Health Screen, have only moderate sensitivity and are frequently not followed by comprehensive assessment or timely intervention [38,39]. As a result, individuals with active psychosis, severe depression, or acute suicidality may be placed in general population housing without protective measures.

1.4.2. Psychotropic Medication Practices

Psychotropic medications are widely prescribed in prisons, often at higher rates than in the community, but the quality of prescribing is questionable. A large study of U.S. prisons found that 25% of prisoners were prescribed an antidepressant, 10% an antipsychotic, and 6% a mood stabilizer [40]. However, polypharmacy, the use of multiple psychotropic drugs without clear indication, is common, as are inadequate dosing regimens and a near absence of concomitant psychotherapy [41,42]. Long acting injectable antipsychotics are sometimes used coercively for behavioral control rather than for genuine therapeutic benefit, raising serious ethical concerns [43].

1.4.3. Psychotherapy and Programming

Evidence based psychotherapies, cognitive behavioral

therapy (CBT), dialectical behavior therapy (DBT), trauma informed care, and cognitive processing therapy, are rarely available at adequate intensity or duration in carceral settings [44]. Waitlists for individual or group therapy can exceed six months, and many facilities employ only one part time psychologist for hundreds of prisoners. Peer support programs, in which trained incarcerated individuals provide mutual aid and crisis support, show considerable promise but remain dramatically underfunded and understudied [45,46].

1.4.4. Suicide Prevention

Despite clear guidance from organizations such as the World Health Organization, many prisons lack robust suicide prevention protocols [47]. Essential elements include environmental modifications to eliminate ligature points (e.g., exposed pipes, hooks, torn sheets), continuous observation for individuals at high risk, adequate crisis intervention staffing, and routine post incident reviews. Few facilities meet all these standards [15,48]. Staff training on mental health recognition and crisis de escalation is often minimal, leaving correctional officers unprepared to identify or respond to psychiatric emergencies [49].

1.5. Ethical Dilemmas in Carceral Psychiatry

Psychiatrists working in prisons face profound and often unavoidable ethical tensions. The dual loyalty problem, obligations to the patient (the incarcerated individual) versus obligation to the institution (the prison administration), is acute and pervasive [50,51]. Correctional authorities may request that psychiatrists manage disruptive behavior via sedation, restraint, or segregation, conflating security needs with medical treatment. When psychiatrists comply, they risk acting as agents of social control rather than as healers [43,52]. Coercive treatment, the forced administration of psychotropic medication to individuals deemed incompetent to refuse or dangerous, is legally permissible in many jurisdictions under the rationale of restoring competency to stand trial [53]. Yet critics argue that this practice subverts the patient's fundamental autonomy and transforms psychiatry into an arm of the court, prioritizing legal outcomes over clinical well being [54]. Furthermore, confidentiality is routinely breached in prison settings. Medical records are accessible to non clinical staff, including correctional officers and administrators, and treatment decisions can be overridden or altered based on security concerns [55,56]. Many psychiatrists report high levels of moral distress, burnout, and professional isolation as a result of these conflicting demands [57]. Without systemic change, these ethical dilemmas will continue to drive skilled clinicians away from correctional practice, further degrading the quality of care.

1.6. Evidence Based Reforms and Alternatives

Meaningful change requires shifting mental health care out of prisons entirely. A growing evidence base supports several specific interventions that reduce harm and improve outcomes.

1.6.1. Pretrial Diversion and Crisis Intervention Teams

Police based Crisis Intervention Teams (CIT) train officers to recognize mental health crises, de escalate situations, and divert individuals to treatment rather than jail. Meta analyses indicate that CIT programs reduce arrests and increase referrals to community mental health services, although effects on use of force are mixed [58,59]. Pretrial diversion programs for low level offenses, when coupled with intensive case management and housing support, reduce recidivism by 30–50% [60].

1.6.2. Mental Health Courts

Mental health courts (MHCs) are specialized dockets that offer community based treatment in lieu of incarceration, typically with judicial monitoring. A systematic review found that MHCs significantly reduce re arrest rates compared to traditional criminal courts [61,62]. However, some critics caution that MHCs may widen net widening, bringing people into the legal system who would otherwise have no contact, and may coerce treatment compliance through the threat of incarceration [63].

1.6.3. Prison Based Therapeutic Communities

Therapeutic communities (TCs) within prisons focus on long term rehabilitation through structured group living, peer support, shared responsibility, and gradual reintegration. For individuals with co occurring substance use and mental disorders, TCs reduce reincarceration rates by 15–25% compared to standard prison housing [64,65].

1.6.4. Step Down Units and Transitional Care

The reentry period following release from prison is a time of extreme risk: mortality rates rise 12 fold in the first two weeks after release, largely due to overdose, suicide, and cardiovascular events [66,67]. Step down units (halfway houses with mental health staffing), transitional case management, and automatic Medicaid enrollment upon release dramatically improve continuity of care and reduce reincarceration [41,68]. The "Forensic Assertive Community Treatment" (FACT) model, widely used in Europe, provides intensive, multi disciplinary, community based support specifically for individuals leaving forensic settings [69,70].

1.6.5. Reducing Solitary Confinement

Limiting solitary confinement to hours rather than days, eliminating its use entirely for people with serious mental illness, and providing step down programs for those leaving restrictive housing all reduce psychiatric morbidity [30,71]. Several U.S. states (e.g., Colorado, New York) have successfully reduced their solitary confinement populations by 60–80% without any associated increase in violence against staff or other prisoners. These reforms demonstrate that safety and humanity are not mutually exclusive.

2. Conclusion and Policy Imperatives

The current system is untenable. Prisons have become warehouses for people with mental illness, providing neither safety nor recovery. The data are unmistakable: individuals

with psychiatric disorders cycle through correctional facilities at rates that dwarf community prevalence; once inside, they face solitary confinement, violence, inadequate treatment, and profound ethical neglect; and upon release, they experience dramatically elevated risks of death and reincarceration. Psychiatry as a profession, by collaborating too closely with carceral logics, by accepting the role of medicating prisoners into compliance, and by remaining largely silent in the face of mass incarceration, has often enabled rather than resisted this reality. This must change. To move forward, the PI proposes four interconnected policy imperatives, each grounded in the evidence reviewed above.

2.1. First, Decarcerate Mental Illness

This means eliminating criminal penalties for nonviolent behaviors that are driven directly by untreated psychiatric symptoms. Trespassing, disorderly conduct, public nuisance, and petty theft should be addressed through health and social service channels, not through arrest and prosecution. Diversion should occur at the earliest possible point of contact, by police, by prosecutors, and by judges. Jurisdictions that have implemented systematic pretrial diversion programs have seen reductions in jail populations without increases in crime [60]. Decarceration also requires re examining parole and probation conditions that trigger reincarceration for technical violations related to mental illness, such as missing an appointment.

2.2. Second, Invest Heavily in Community Based Crisis Services

For every dollar spent on incarceration, a fraction reinvested in community mental health would yield better clinical and public safety outcomes. Mobile crisis teams, 24/7 walk in crisis stabilization centers, short term residential crisis units, and supportive housing with on site mental health staff can replace jail for the vast majority of individuals currently cycled through the system [72,73]. These services must be available without long waitlists, without insurance barriers, and without the threat of legal coercion.

2.3. Third, Fundamentally Transform Prison Psychiatry for the Smaller Number of Individuals who Remain Incarcerated

This transformation has several components:

- An immediate ban on solitary confinement for anyone with a serious mental illness, along with strict time limits (hours, not days) for all others.
- Expansion of evidence based psychotherapies to at least the same standard of care available in the community.
- Independent medical oversight of all psychiatric prescribing, with prohibitions on using medications solely for behavioral control.
- Mandatory ethics training for all forensic psychiatrists, emphasizing the primacy of the patient over the institution.
- Suicide prevention protocols that meet World Health Organization standards in every facility [74].

2.4. Fourth, Fund Reentry and Post Release Housing as A Psychiatric Intervention

Release from prison without a plan for housing, medication continuity, income, and social support is a recipe for rapid decompensation and reincarceration. Stable housing is perhaps the single most powerful predictor of successful reentry; Medicaid coverage for mental health and substance use treatment must be active on the day of release, not weeks later; peer support specialists with lived experience of incarceration can provide culturally competent guidance and hope [75-77]. Reentry case management should begin at least 90 days before release and continue for at least six months afterward. One thing is clear and too often dismissed: mental illness is not a crime. The response to psychiatric distress should be a helping hand, not handcuffs; a hospital bed, not a prison cell; a therapist's office, not a courtroom. The path forward is not more prison beds but more clinic beds, not more security but more solidarity, not more punishment but more compassion. The Journal of Mental Health and Psychiatry Research urges researchers, clinicians, policymakers, and advocates to treat the mass incarceration of people with mental illness as the human rights emergency it is, and to act with the urgency that emergency demands. Every day of delay means another person with a treatable condition enters a prison that will worsen their illness, another suicide in a segregation cell, another preventable death after release. The evidence is clear. The moral imperative is undeniable. The time for change is now.

References

1. Center, T. A. (2014). The Treatment of Persons with Mental Illness in Prisons and Jails.
2. Prins, S. J. (2019). Prevalence of serious mental illness in US jails. Psychiatric Services, 70(7), 561-568.
3. Fazel, S., & Seewald, K. (2012). Severe mental illness in 33 588 prisoners worldwide: systematicreview and meta-regression analysis. *The British journal of psychiatry, 200*(5), 364-373.
4. Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric services, 60*(6), 761-765.
5. Lamb, H. R., & Weinberger, L. E. (2017). Deinstitutionalization and criminalization. Schizophrenia Bulletin, 43(1), 22-25.
6. Fisher, W. H., et al. (2021). Criminalization of mental illness. Annual Review of Clinical Psychology, 17, 543-568.
7. Haney, C. (2018). Post-incarceration syndrome. Psychology, Public Policy, and Law, 24(4), 399-414.
8. Kaba, F., et al. (2014). Solitary confinement and self-harm. American Journal of Public Health, 104(5), e52-e57.
9. Fazel, S., et al. (2016). Depression in prisoners. Lancet Psychiatry, 3(4), 355-366.
10. Baranyi, G., et al. (2018). Prevalence of PTSD in prisoners. Lancet Public Health, 3(4), e190-e200.
11. Goff, A., et al. (2014). Trauma and prisoners. Trauma, Violence, & Abuse, 15(4), 318-330.

12. Lynch, S. M., et al. (2014). Women in prison: Mental health. Women & Therapy, 37(3-4), 246-264.
13. Abram, K. M., Paskar, L. D., Washburn, J. J., Teplin, L. A., Zwecker, N. A., & Azores-Gococo, N. M. (2015). Perceived Barriers to Mental Health Services among Detained Youth. Juvenile Justice Bulletin. NCJ 248522. *Office of Juvenile Justice and Delinquency Prevention.*
14. Underwood, L. A., & Washington, A. (2016). Mental illness and juvenile offenders. *International journal of environmental research and public health, 13*(2), 228.
15. Fazel, S., et al. (2017). Suicide in prisons. Lancet Public Health, 2(5), e233-e241.
16. Hayes, L. M. (2013). Suicide prevention in correctional facilities: Reflections and next steps. *International journal of law and psychiatry, 36*(3-4), 188-194.
17. Prins, S. J. (2020). Cross-national comparisons of prison mental health. Health & Justice, 8(1), 12.
18. Dudeck, M., et al. (2019). Nordic versus US prison mental health. International Journal of Law and Psychiatry, 66, 101458.
19. Scull, A. (2015). Deinstitutionalization revisited. The Lancet Psychiatry, 2(12), 1097-1103.
20. Torrey, E. F. (2015). Deinstitutionalization and the rise of incarceration. International Journal of Law and Psychiatry, 38, 11-19.
21. Frank, R. G., & Glied, S. A. (2016). Deinstitutionalization funding. Health Affairs, 35(8), 1462-1469.
22. Mechanic, D., & Rochefort, D. A. (2019). Deinstitutionalization policy. Milbank Quarterly, 97(1), 248-283.
23. Massoglia, M., & Pridemore, W. A. (2015). Incarceration and health. *Annual review of sociology, 41*(1), 291-310.
24. Phelps, M. S. (2018). Mass incarceration origins. Annual Review of Criminology, 1, 283-306.
25. Skeem, J. L., et al. (2014). Arrest and mental illness. Clinical Psychological Science, 2(4), 446-465.
26. Perez, A., et al. (2021). Testing the Penrose hypothesis. International Journal of Law and Psychiatry, 74, 101653.
27. Chow, W. S., & Priebe, S. (2013). Penrose hypothesis. Social Psychiatry and Psychiatric Epidemiology, 48(1), 1-4.
28. Haney, C. (2003). Mental health and prisonization. In Prisoners Once Removed (pp. 25-52). Urban Institute Press.
29. Chakofsky-Lewy, N. (2020). *Solitary Confinement and Mental Illness: A Review of State Policies in the US*. University of Hartford.
30. Cloud, D. H., et al. (2015). Solitary confinement and mental illness. American Journal of Public Health, 105(8), 1591-1597.
31. Listwan, S. J., et al. (2014). Victimization in prison. Crime and Delinquency, 60(6), 860-881.
32. Blitz, C. L., et al. (2008). Victimization and mental illness in prisons. Journal of Interpersonal Violence, 23(6), 793-810.
33. Binswanger, I. A., et al. (2016). Overcrowding and mental health in prisons. American Journal of Preventive Medicine, 50(5), 627-634.
34. Dewa, L. H., et al. (2018). Sleep deprivation in prisons. Sleep Medicine Reviews, 41, 68-75.
35. Genty, P. M. (1996). Confusing punishment with custodial care: The troublesome legacy of Estelle v. Gamble. *Vt. L. Rev., 21*, 379.
36. Ruch, D. A., et al. (2021). Suicide risk in first 24 hours. JAMA Psychiatry, 78(8), 848-856.
37. Steadman, H. J., Scott, J. E., Osher, F., Agnese, T. K., & Robbins, P. C. (2005). Validation of the brief jail mental health screen. *Psychiatric Services, 56*(7), 816-822.
38. Ford, J. D., et al. (2019). Screening tools in jails. Psychological Services, 16(4), 610-618.
39. Nussbaum, D., et al. (2018). Intake mental health screening. Criminal Justice and Behavior, 45(7), 1012-1030.
40. Al-Rousan, T., et al. (2017). Psychotropic medication uses in U.S. prisons. JAMA Internal Medicine, 177(4), 583-585.
41. Baillargeon, J., et al. (2016). Psychiatric disorders and repeat incarcerations. American Journal of Public Health, 106(2), 307-313.
42. Reingle Gonzalez, J. M., et al. (2017). Polypharmacy in prison. Journal of Psychiatric Practice, 23(6), 407-414.
43. Barton, D., & Casher, M. (2020). Coercive medication in corrections. Journal of the American Academy of Psychiatry and the Law, 48(3), 312-320.
44. Morgan, R. D., et al. (2020). CBT in prisons. Journal of Consulting and Clinical Psychology, 88(6), 532-545.
45. Dell, N. A., et al. (2019). Peer support in prisons. Psychiatric Rehabilitation Journal, 42(3), 268-276.
46. South, J., et al. (2018). Peer support in prison settings. Journal of Public Mental Health, 17(4), 163-172.
47. WHO (World Health Organization). (2020). Preventing suicide in jails and prisons. WHO Regional Office for Europe.
48. Konrad, N., et al. (2019). WHO guidelines for prison suicide prevention. Crisis, 40(6), 431-439.
49. Appelbaum, P. S. (2018). Mental health in corrections. Psychiatric Services, 69(2), 126-128.
50. Glover-Thomas, N. (2019). Dual loyalty in prison health. Medical Law Review, 27(2), 278-302.
51. Adshead, G. (2020). Ethics in prison psychiatry. Current Opinion in Psychiatry, 33(5), 450-454.
52. Tucker, D., & Lu, F. G. (2019). Ethics of coercive treatment. Focus, 17(3), 262-268.
53. Breneman, D. A. (2003). Forcible antipsychotic medication and the unfortunate side effects of Sell v. United States, 539 US 166, 123 S. Ct. 2174 (2003).
54. Pouncey, C. L., & Lukens, J. M. (2018). Coercion versus autonomy. Philosophy, Psychiatry, & Psychology, 25(2), 115-128.
55. Freckelton, I. (2018). Confidentiality in prison psychiatry. Psychiatry, Psychology and Law, 25(3), 337-356.
56. Simpson, A. I., & Penney, S. R. (2018). Confidentiality and security. International Journal of Forensic Mental Health, 17(4), 367-377.
57. Moll, J., & Foster, E. (2021). Moral distress in carceral psychiatry. Journal of Medical Ethics, 47(5), 342-348.

58. Taheri, S. A. (2016). CIT effectiveness: A meta-analysis. Criminal Justice and Behavior, 43(8), 1093-1110.
59. Rogers, M. S., et al. (2019). CIT effectiveness. Police Quarterly, 22(3), 333-364.
60. Steadman, H. J., et al. (2014). Pretrial diversion for people with mental illness. Law and Human Behavior, 38(5), 467-476.
61. Campbell, M. A., et al. (2020). Mental health courts: A systematic review. Law and Human Behavior, 44(4), 277-294.
62. Lowder, E. M., et al. (2018). Mental health courts: Recidivism outcomes. Psychiatric Services, 69(3), 296-303.
63. Snedker, K. A. (2020). Mental health courts and net-widening. Social Problems, 67(2), 310-328.
64. Mitchell, O., et al. (2017). Prison-based TC recidivism. Journal of Experimental Criminology, 13(3), 311-333.
65. Maglione, M. A., et al. (2018). Prison TC effectiveness. Journal of Substance Abuse Treatment, 92, 44-51.
66. Binswanger, I. A., et al. (2011). Mortality after prison release. New England Journal of Medicine, 364(8), 713-723.
67. Pizzicato, L. N., et al. (2018). Reentry mortality. Journal of Correctional Health Care, 24(4), 377-386.
68. Flanagan, N. A., et al. (2019). Reentry care coordination. Health & Justice, 7(1), 5.
69. Lamers, T., et al. (2021). Forensic ACT in Europe. International Journal of Forensic Mental Health, 20(2), 143-155.
70. Calsyn, R. J., & Winter, J. P. (2019). ACT in forensic settings. Administration and Policy in Mental Health, 46(2), 145-154.
71. Gendreau, P., & Goggin, C. (2021). Solitary confinement effects. Criminal Justice and Behavior, 48(2), 123-140.
72. Bond, G. R., Drake, R. E., & Florence, A. C. (2025). A framework for evaluating psychiatric rehabilitation practices. *Psychiatric Rehabilitation Journal.*
73. Johnson, K. A., et al. (2019). Mobile crisis teams. Psychiatric Services, 70(7), 600-603.
74. Pieh, C., et al. (2019). Training forensic psychiatrists. Academic Psychiatry, 43(5), 511-515.
75. Lutman, G., & Bender, K. (2021). Housing after prison. Journal of Social Distress and Homelessness, 30(1), 44-53.
76. Tsai, J., et al. (2020). Housing and reincarceration. American Journal of Preventive Medicine, 58(4), 523-531.
77. Penrose, L. S. (1939). The inverse relationship between prison beds and mental hospital beds. British Journal of Medical Psychology, 18(3), 294-302.