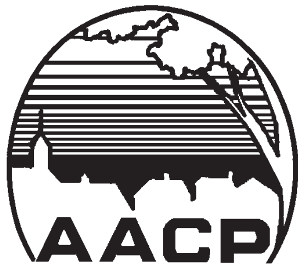


A PUBLICATION OF THE AMERICAN ASSOCIATION FOR COMMUNITY PSYCHIATRY
WWW.COMMUNITYPSYCHIATRY.ORG

Community Psychiatrist

Spring 2022 Volume 36, Number 1

President's Column

By: Michael Flaum, MD

This will be my last column as AACP president. In preparing for this, it seemed appropriate to look back on the first of these president's columns I wrote, six years ago. In that first column, I speculated that perhaps the fact that my predecessor in this role, Anita Everett, was moving from the presidency of AACP to that of the APA signaled a closer alignment between "mainstream American psychiatry" and the issues and values that have been at the core of this organization since its origins. That is, a recognition of the need for psychiatry to broaden its clinical focus beyond pharmacology and diagnosis, towards a more collaborative, person-centered, recovery-oriented approach with the individuals we serve, as well as a more structurally competent understanding of the systems in which we all live and operate and how these factors impact our patients' lives. In that first column, I also discussed an article that had just come out by Dr. Tom Insel, who had stepped down the previous year from his longstanding position as director of the National Institute of Mental Health. I was heartened to that he was talking about the importance of the RAISE study (Recovery After Initial Schizophrenia Episode), as this was one of the very few large-scale research projects that NIMH had supported under his tenure that was focused on the goal of optimizing outcomes for those currently in need, rather than on the promise of elucidating underlying biological mechanisms through genomics and neuroscience. Perhaps this was another sign of a shift. It felt like an exciting time for community psychiatry, and I suggested that we should "buckle up".

That last piece of advice proved to be sound, as it certainly has been a turbulent ride for much of the time since. It is the case that many of the priorities of community psychiatry have indeed come to center stage, not only within psychiatry but much more broadly, although not for reasons that anyone would have chosen. In light of the many stressors we've collectively faced, there is certainly a greater recognition of the importance of mental health as core to the health of individuals, communities and the country. People across all walks of life seem to be aware of, and appropriately concerned about, the rising rates of the "diseases of despair" including suicide and substance abuse, along with increases in the prevalence of anxiety and attentional problems, especially among youth. The racial tensions that reached a tipping point with the murder of George Floyd directly pointed to so many issues, including the need to enhance the role of mental health and crisis services in our communities, ideally allowing for less reliance on the police and carceral systems. This increased awareness has resulted in some additional financial resources directed towards mental health, especially at the federal level. Indeed, there is probably more money being made available to enhance mental health services than at any time in recent memory.

In this issue:

President's Column ... Pg. 1
Community Advocacy ... Pg. 4
Vaccinating the vulnerable: Encouraging COVID-19 vaccination for patients with serious mental illness ... Pg. 4
Thousands of asylum seekers remain in danger in Mexican Border Towns - Who will be their Moses? ... Pg. 6
The Intersection of Mental Health, Public Health, and Solitary Confinement ... Pg. 9
Community Perspectives ... Pg. 13
Horseshoe Farm Fellowship: A Reflection ... Pg. 13
A Pandemic of Mistrust ... Pg. 15
Community Updates/Special Thanks ... Pg. 17
In Memoriam ... Pg. 18

A recent book by Dr. Insel begins with an admission of his "aha moment" a few years ago, in which he recognized that going all in on the promise of neuroscience and genomics may have been misguided. (He is slated to be the keynote speaker at the Mental Health Services meeting in the fall in which he will likely discuss this). Thankfully, the relatively small investment that NIMH made in the RAISE study contributed to the successful translation of that research into practice, now with federal funding for the implementation of First Episode Psychosis teams all across the country. This proactive, person-centered, team-based approach provides a full range of services to those who appear to be early in the course of psychotic illnesses, hopefully changing the lifelong trajectory of the impact of those illnesses on individuals and their families. It's a great example of a community psychiatry approach.

Crisis services are now expanding broadly across the country as well, both through the rapidly growing implementation of CCBHC's as well as the upcoming launch of the 988 number. There are still a wide variety of issues and concerns to work out as to how these new crisis services will overlay onto the existing mental health framework, but the availability of more resources and the attention to these issues is a certainly a positive development, and another example of community psychiatry at the forefront.

Three of the past six APA presidents have been leaders in community psychiatry, with Altha Stewart immediately following Anita, and Jeffrey Geller serving as APA president during the particularly challenging year of 2020-21. Thanks in part to their leadership, the focus of the APA, which is a reasonable proxy for mainstream American psychiatry does seem to be shifting its focus to some extent. The APA undertook ambitious task forces on Structural Racism in psychiatry in 2020, followed by one last year on the Social Determinants of Mental Health. (Indeed, that is the theme of this year's Annual APA meeting). Whether those task forces result in any meaningful change in real world policies or practice remains to be seen, but the fact that they were a focus of APA activity is in and of itself noteworthy.

At the same time, the increasing demand for, and recognition of the ever-expanding need for psychiatric and other mental health services has placed an enormous strain on an already overly stretched workforce. The move to telepsychiatry was remarkable in how swiftly it occurred in response to the onset of the pandemic, and it has dramatically enhanced access to services. However, it has left much of the workforce less connected to their peers and support systems, and therefore more vulnerable to the effects of what has been controversially labeled as "burnout". Whatever we choose to call this phenomenon, it is something we are going to have to attend to. Indeed, one of the reasons that I am so passionate about the importance of peer professional organizations like AACP, is that there is strong evidence that peer support and especially support from those more senior, is a key factor in mitigating burnout. We had a wonderful example of this last month on one of the AACP Policy and Advocacy Forums. An early career psychiatrist joined the call and had the courage to speak up a bit among lots of old timers and familiar faces. After the call, she e-mailed Dr. Stewart and me, thanking us and admitting that just that week she had been looking at other jobs outside of community psychiatry because she wasn't sure she could continue to do this work feeling as unsupported and alone with it as she had been. She said that after just spending the hour on the call with us all, she felt a renewed commitment to continue. For me, that justified not only that particular forum, but so much of the work that I've been privileged to be involved with along with many others in this organization over the years. We need each other. We need the connection. Whether it is a connection between us and our patients through a genuinely collaborative approach; or a connection to a team of colleagues such as those working on an ACT or First Episode Psychosis team; or a connection fostered by membership in a peer professional organization like AACP; etc. Fostering supportive connections between one human being and another is key.

Before the APA meeting in NOLA, I plan to stop in Greensboro, Alabama, to visit Project Horseshoe Farm . This is a program that provides one-year "community health fellowships", usually as a gap year between college and medical school. There is a brief article from one of the program's current fellows in this issue. As I understand it, they basically give these young people the opportunity to walk alongside and provide assistance to people in need from the community, ranging from children to adults with mental health problems to seniors. The hope is that the fellows really get to know and make meaningful connections with at least few of these people, allowing them to understand the factors that impact their lives and their health. I learned of this program from a first-year medical student whose level of sophistication and concern about the state of our healthcare system was far greater than most at his level. He attributed it to the year he spent at Horseshoe Farm and suggested I check it out. I don't know what field he will ultimately choose, but my guess is that he will approach whatever he pursues with the spirit of a community psychiatrist. What is that spirit?

The first column I ever wrote in this newsletter was a few years before I became board president. It was a piece that on the surface was about what we should call this field of ours. I noted that there seemed to be a lot of confusion about what was meant by the term "community psychiatry," even among many of my psychiatric colleagues and certainly among students and residents. I noted that there was a split among fellowship programs, with some referring to it as "community psychiatry", others as "public psychiatry" and some combining the two. Would it be clearer if we all referred to it the same way – and if so, which term was preferable? I made the intentionally provocative suggestion of considering a different moniker altogether. I suggested that perhaps we should call it "Psychiatry", i.e., that perhaps we shouldn't think of it as a subspecialty at all, but rather, promote the idea that the core aspects of what we do should be fundamental for all psychiatrists. This would start with the importance of making real connections with the people we serve to allow for meaningful person-centered care; it would emphasize the need to think about providing services to populations as well as individuals, especially those who require a safety net (whether that safety net currently exists or not); It would require a solid grounding in structural competence ; it would help learners think about causative mechanisms from a systems as well as a biological perspective, including the social determinants of mental health; and it would encourage psychiatrists to

pursue seats at the table in driving policy within the systems in which they work and interface, not just in their spare time but as a core part of their job and professional identity.

These are admittedly lofty goals. But I think this is the work that many in AACP already do, and the need has never been greater. There is a hunger among young people entering our field to do this work, if adequately supported and inspired to do so. We need to grow this, and I'm hopeful that AACP can play a key role in doing so for many years to come.

It has been a great privilege for me to have had the opportunity to serve this organization as its board president. I am immensely grateful to Dr. Altha Stewart for agreeing to allow me to pass the baton to her. I can literally think of no one better to lead and inspire the next generation of community psychiatry, and hopefully to bring the spirit, values and priorities of community psychiatry to the broader psychiatric and mental health community.

Finally, a big thank you to Isabel Norian for putting her heart and soul into this newsletter over the last four years, Liz Frye before her, and each of the APA Public Psychiatry fellows who have served as assistant editors.

Michael Flaum, MD

[1]*Insel, T. "RAISE-ing Our Expectations for First-Episode Psychosis." Am J Psychiatry, 173(4), 311–312, 2016*

[2]*Insel, T. Healing: Our Path from Mental Illness to Mental Health. Penguin Press, New York, 2022*

[3]*Project Horseshoe Farm: Downloaded from: https://www.projecthsf.org/gap-year-fellowship*

[4]*Metzl JM, Hansen H. Structural Competency and Psychiatry. JAMA Psychiatry. 2018;75(2):115–116*

Vaccinating the vulnerable: Encouraging COVID-19 vaccination for patients with serious mental illness

By: Carol Lim, MD, MPH and Oliver Freudenreich, MD, FACLP

When the pandemic first hit, we—like many other colleagues in the medical field—were nervous about what the future would hold while busy learning the basics of infection control and trying to decide how to best manage our patients with serious mental illness (SMI). As community psychiatrists working in a community mental health clinic in downtown Boston (i.e., the Freedom Trail Clinic), it was obvious that we couldn't simply shut down—doing so would cause harm to our patients, especially those on clozapine and long-acting injectable antipsychotics who need more involved care. While a broad shift to telepsychiatry took place in psychiatry, we had to carry on in-person visits with some trepidation. Many of our patients did not have access to technology, were too impaired to use technology, or needed blood work or injections.

Our worst fears of did not come to pass. We were fortunate not to have a major outbreak in our clinic during the first few months of the pandemic when the exact mode of transmission was still unknown. Data confirmed that our fears were not unfounded–-people with SMI were at much higher risk of COVID-19 infection and death from it. One study from New York suggested schizophrenia alone was the second leading predictor of death from COVID-19 after age (1).

We were optimistic when vaccines were approved and became widely available in the early months of 2021. However, we were surprised by our patients' initial reactions—many did not know why vaccines were needed. They were confused and scared with rapidly evolving information, not knowing what to believe. Many questioned vaccine efficacy or believed they were harmful. We realized we needed to do more to help and protect our vulnerable patients and continue to provide them with high quality care, including paying attention to infection control. The clinic and our administrative leadership wholeheartedly agreed with the American Psychiatric Association (APA) who helpfully advocated for the increased involvement of psychiatrists in encouraging their patients to get vaccinated (2).

We were pleased with APA's collective stance—its commitment mirrored our own efforts. We discovered that we were often our patients' sole medical providers and primary point of healthcare contact due to interruptions in nonemergent services caused by the COVID-19 pandemic. As psychiatrists, we realized our skills could be tailored to provide information about COVID-19. Having been trained in behavioral management techniques such as motivational interviewing, we recognized our potential to help resolve patients' vaccine hesitancy and provide up to date information about the pandemic to our patients with SMI. We were uniquely prepared to educate people in these often-overlooked communities about the importance of vaccination. "Why not apply our unique behavioral management skillset to help our patients get vaccinated?" we thought (3).

While we agreed psychiatrists could serve as useful resources to help address vaccine hesitancy among patients with SMI, standardizing our approach during outpatient visits proved challenging. We worried that requiring busy community psychiatric providers to complete COVID-19 related behavioral assessments during their routine 15-minute check-ins could be overwhelming. To efficiently change provider practices, we created and implemented an easy-to-use vaccination monitoring tool integrated into the Electronic Medical Record to track vaccination intention, hesitancy, and uptake at each visit. We were fortunate to have Dr. Manjola Van Alphen, the CMO of North Suffolk Mental Health Association, enthusiastically support this system-level effort. In-service education was provided to our clinicians to help them better address vaccine-related concerns using the tool we developed. We held monthly "med-psych" vaccine rounds to review the progress as a clinic starting in February 2021.

Many of our patients were initially unfamiliar with the utility of COVID-19 vaccination. Although several patients cited vaccine conspiracy theories, most were concerned about side effects due to the vaccines' rapid development. These patients benefited from education, and the majority reported they had been vaccinated by the end of June 2021. Practical barriers such as scheduling, transportation, remembering appointments often prevented otherwise willing patients (41% of the unvaccinated by the end of study) from getting vaccinated. Patients with SMI needed extra help given cognitive limitations associated with schizophrenia and other mental disorders that made planning and follow-up challenging. All clinicians at the Freedom Trail Clinic worked tirelessly with care teams and family members to help patients overcome barriers to care. The percentage of fully vaccinated patients in our cohort of about 200 clozapine patients rose to 84%, significantly higher than the Massachusetts average which hovered between 62% and 77% at the end of June 2021 (4). We were proud to have managed to vaccinate nearly the entire clinic.

"The vaccine project," as we ended up calling our efforts, will be remembered by us as a proud achievement, showing what psychiatrists can achieve when not unburdened by bureaucracy and regulatory concerns. We believe that we did not only make a profound difference in our patients' lives, but that we ourselves developed a sense of purpose, commensurate with our training. We hope our study serves as an example of how community psychiatrists can be active in public health efforts, carrying over this sense of enthusiasm and "can-do" attitude to the post-pandemic period. For now, we are planning to prepare for the fall and making vaccine-preventable illnesses a legitimate concern for community psychiatry, broadening our discussions beyond COVID-19. Perhaps our story inspires others to take an active role in public health and infection control efforts, beyond more traditional psychiatric tasks.

References
1. Nemani K, Li C, Olfson M, et al. Association of psychiatric disorders with mortality among patients with COVID-19. JAMA psychiatry. 2021;78(4):380-6.
2. COVID-19 Pandemic Guidance Document: The Role of the Psychiatrist in the Equitable Distribution of the Covid-19 Vaccine. Washington, DC, American Psychiatric Association, 2021. www.psychiatry.org/File%20Library/Psychiatrists/APA-Guidance-Psychiatrists-Role-in-Equitable-Distribution-COVID-19-Vaccine.pdf
3. Lim C, Van Alphen M, Freudenreich O. Becoming vaccine ambassadors: A new role for psychiatrists. Curr Psychiatry. 2021;20(8):10-1.
4. Lim C, Van Alphen M, Maclaurin S, Mulligan C, Macri B, Cather C, Freudenreich O. Increasing COVID-19 vaccination rates among patients with serious mental illness: A pilot intervention study. Psychiatric Services. 2022 April 13

Dr. Lim is Psychiatrist, MGH Psychosis Clinical and Research Program and Instructor in Psychiatry at Massachusetts General Hospital, Harvard Medical School.

Dr. Freudenreich is Co-Director, MGH Psychosis Clinical and Research Program and Associate Professor of Psychiatry, Massachusetts General Hospital, Harvard Medical School.

Thousands of asylum seekers remain in danger in Mexican Border Towns – Who will be their Moses?

By: Rev. Carol L. Kessler, MD, MDiv. FAPA, DFAACAP

In this season of Passover and Holy Week, many of us remember peoples' liberation from bondage; people crossing the sea; people witnessing crucifixion and standing in hope of resurrection. And in this season, we witness the plight of today's refugees. Our screens are filled with images of Ukraine. I am heartened to speak with my aunt in Germany as she shares of neighbors opening their homes to welcome Ukrainian strangers, and thereby greeting angels unawares.

Yet my soul is heavy with more than three decades of accompanying Central Americans fleeing violence yet not being granted asylum in the country my German parents immigrated to after WWII – the US. I carry the legacy of feeling responsible to see the concentration camps of my time and to cry out to the world of their existence. And so, my ties to El Salvador began when I volunteered for a health project of the Salvadoran Archdiocese in 1987, in the conflict zone of Chalatenango at a time where the Salvadoran government's slogan was "Be a patriot! Kill a priest!" At a time, when US health professionals were in demand for, we were less likely to be targeted by dollar backed bullets; for the US sent an average of one million dollars daily to support the Salvadoran military.

During twelve years of war, only one percent of Salvadorans were granted political asylum since the US considered El Salvador to be a democracy that it was supporting against the threat of communism. I recall the day in Long Island, New York, when I accompanied an attorney from the Central American Refugee Committee to support a thirteen-year-old boy I had evaluated psychiatrically and determined to suffer from Acute Stress Disorder and Major Depression as he faced the threat of deportation at a time when the Salvadoran military routinely took boys from rural buses to convert them into child soldiers. Exasperated, the immigration judge shouted, "Do you want me to grant all Salvadoran boys' political asylum?!"

Peace accords were eventually signed in 1992 as the FMLN guerilla became a political party and the military/death squads were disbanded. A civilian police force was created to replace the National Police accused of torture and disappearances. At this fragile time, the US opened prisons that housed thousands of members of MS13 and Calle 18 gangs—gangs formed by undocumented Salvadorans in LA who lacked a legal path forward as they confronted the gang-ridden LA streets. As a result, the Northern Triangle of El Salvador, Honduras, and Guatemala has become a homicide capital of the world, where gangs reign supreme.

And so, for the past couple of decades, Central Americans flee primarily gang and domestic violence, risking their lives with the hope of crossing over to the United States, where they might find asylum/safety from extortion, kidnapping, rape, and murder. As a volunteer psychiatrist with Physicians for Human Rights' Asylum network, I have provided countless affidavits documenting the invisible psychic wounds inflicted by gangs, for the odds of being granted asylum increase tremendously with such expert documentation of harm.

Yet, the US has increasingly looked at horror at caravans of Central Americans arriving at the border, deeming them villains, and failing to acknowledge the harm that US intervention has caused their homelands. Most were horrified by Trump's "zero tolerance policy" in 2018, wherein parents' and guardians' children were taken from them as they were criminally prosecuted, while more than 2000 children were placed in custody of the Office of Refugee Resettlement and sent to detention centers to await placement with a US based family member or foster parent, or voluntary departure to their home country.

When I recently evaluated a woman in Guatemala who has been forcibly separated from her daughter for three years, she recalled the moment when she begged the Border Patrol Agent not to take her child and was met with the response: "I am following my President's orders." My documentation of her ongoing psychic trauma on behalf of a project of Physicians for Human Rights seeks to denounce harm inflicted by US policy and call for reparations. When I chose to work in a detention center for "unaccompanied" minors some time ago, I was morally compelled to leave rather than be complicit in medicating youth with psychoactive substances for symptoms caused by my country's immigration policies.

While the "zero tolerance" policy has been phased out, the plight of children and families at the Mexican border remains a humanitarian disaster, supported by current US immigration policies—Title 42 and MPP/Remain in Mexico. Recent advocacy has led to the prospect of overturning Title 42—a policy that has prohibited entry of asylum seekers based on the premise of preventing COVID transmission. Yet, opponents are finding ways to fight back against the dismantlement of Title 42 scheduled for the end of May.

Whether or not Title 42 is overturned, the Migrant Protection Protocols/"Remain in Mexico", that were enacted three years ago, in January 2019, remain in place. In June 2021, MPP was briefly overturned as promised by the Biden administration during the elections, yet was reinstated in December 2021 following orders of a Texas federal judge. At that time, the restrictions of MPP were extended to all asylum seekers from the Western Hemisphere, not only those who are Spanish-speaking or Brazilian targeted during the Trump Administration. These protocols have been denounced since their inception by human rights groups for violating international law that prohibits returning asylum seekers to places where they may be persecuted. https://www.hrw.org/news/2022/02/07/remain-mexico-overview-and-resources#.

MPP protocols target primarily people of color, fleeing immanent threat in countries ravaged by US foreign policy. Those who flee have little hope of having their cases heard in a backlogged US immigration court. They have little hope of obtaining legal representation to inform them of their rights and advocate for a

path to safety. Instead, they remain in dangerous border towns where they fall prey to omnipresent cartels and unsanitary living conditions. It is estimated that more than 71,000 asylum seekers were sent to Mexico by the Trump administration between January 2019 and January 2021. Many have been waiting months to years for their cases to be heard. Meanwhile, human rights groups have documented thousands of reports of kidnapping, extortion, and rape. https://www.hrw.org/news/2022/02/07/remain-mexico-overview-and-resources#.

Most if not all asylum seekers are unaware of an exemption to MPP, wherein those with physical or mental health impairments that face significant vulnerability have the right to enter the United States where they might access appropriate medical care and prevent deterioration of pre-existing conditions. A review of affidavits by Physicians for Human Rights found that more than 10 percent of those returned to Mexico were entitled to the humanitarian exemption. As a result, people with critical medical conditions and invisible psychic wounds are systematically sent to border towns where their disorders will be exacerbated and where they will have no access to care. https://phr.org/our-work/resources/forced-into-danger/

A positive outcome of the COVID pandemic has been the widespread adoption of telehealth that has enabled physicians to partner with attorneys in documenting the health needs of asylum seekers languishing in Mexico so that they may be granted their right to cross a port of entry to the United States. A pioneer in this effort is Jenifer Wolf-Williams who created the organization, H.O.M.E. (Humanitarian Outreach for Migrant Emotional Health), to be a voice for the voiceless (https://homemigration.org/). This effort is also shared by Physicians for Human Rights Asylum Network that has expanded its scope by training the network's physicians to provide forensic evaluations that might lead to letters advocating for humanitarian parole.

By joining this process, I have thereby met children with developmental and intellectual disabilities living in tents or single rooms for months to years without any professional support. I met a single mother of three young children who fled severe domestic violence only to remain confined to a room so as not to endure the common fate of kidnapping, rape, or extortion. She waits to see if my letter on her behalf will be effective in allowing her to cross and wait an asylum hearing in the US, where she will hopefully have access to mental health services and respite from omnipresent cartels. I meet a man who fled El Salvador to flee murder at the hands of gangs that wanted to convert his home into a refuge. He has been waiting three years to reunite with his mother and older sister with Down Syndrome who were successful in crossing the border, yet live in a car in Florida.

I have learned that family separations persist, not at the hands of Border Patrol as they had years ago, but as the heart-rending choice of parents/guardians who encourage youth to cross alone to safety from the omnipresent threat of rape and kidnapping by cartels, knowing that unaccompanied minors are exempt from MPP. Indeed, in the detention center where I worked as a psychiatrist, I encountered a young boy who begged his father to allow him to cross because he had heard that children in the United States have the right to an education. I encountered children separated from guardians at the border due to lack of proper documentation of custody.

Through H.O.M.E founder, Jenifer Wolf Williams, I have become acquainted with the hopeful voice of Holocaust survivor and psychologist, Ervin Straub who that notes that we need not be passive bystanders—seeing no evil, hearing no evil, speaking no evil. For one active bystander can turn the tide toward genocide (Straub, 2009). We each have a choice. We might actively seek information that may not be shown on our mainstream news reports or social media. Organizations—like Families Belong Together, Hebrew Immigrant Aid Society (HIAS), Physicians for Human Rights, the Young Center for Immigrant Children's Rights, and Human Rights First—tirelessly share information that is easily accessible on their websites. The Young Center invites any of us to train to become an advocate for an unaccompanied youth facing the immigration system alone. H.O.M.E. continues to seek mental health professionals, attorneys, interpreters, grant writers, and funders to assist asylum seekers in obtaining humanitarian entry into the US. Medical students have established human rights clinics throughout the country under the auspices of Physicians for Human Rights to accompany, document, and advocate. HIAS has created an urgent appeal to sign a petition (https://act.hias.org/page/37582/petition/1) calling upon the Biden Administration to protect asylum-seekers at the US-Mexico border, and to implement a fair and humane asylum system.

Yael Schacher, deputy director for the Americas and Europe at Refugees claims that a ruling supporting the lawsuit of Texas and Missouri's desire to expand MPP would "further eviscerate current US asylum procedures and set a stark example for the undermining of refugee protocols throughout the world." She fears that these states "want to kill asylum" and instead expand detention of migrants in private prisons. Her expert opinion is that MPP has exposed issues rooted in the immigration courts' relationship with Department of Homeland Security. She urges Congress to consider "the establishment of an immigration court independent of the Department of Justice or the executive branch." https://www.refugeesinternational.org/yael-schacher.

There is hope. To quote Margaret Mead, "Never doubt that a small group of thoughtful, committed citizens, can change the world." This Passover HIAS shares a Haggadah inviting all global refugees to the Passover table. And I recall the faith of Salvadorans under siege, with whom I joined on Good Friday in the 1990s to sing from Canto Hermano/Songs of Brothers, a hymnal that if found in one's home could lead one to be disappeared by US backed military.

For me too they killed Him
And today we kill them too
In every brother who dies, He dies once again
In every sister who dies, He dies once again.

On Holy Thursday, we danced with Judas, that fearful part of ourselves that paralyzes us and kills hope. We stood awaiting the promise of resurrection, by a bonfire, joined in our common vulnerability, as active bystanders whose voices could not be silenced.

May we all join in the song and dance. No longer passive bystanders, but companions creating a path through the wilderness and across the sea to new life for all.

Please reach out to me at luisecarolk@gmail.com should you desire more information on how you might contribute to this effort—as physician; mental health professional; interpreter; citizen; donor.

For together, we can move mountains.

References:

1. *https://www.familiesbelongtogether.org/*
2. *https://www.hias.org/*
3. *https://homemigration.org/*
4. *https://www.houstonpublicmedia.org/articles/news/politics/immigration/2021/08/25/406808/u-s-supreme-court-requires-biden-administration-to-reinstate-trumps-remain-in-mexico-policy/*
5. *https://www.hrw.org/news/2022/02/07/remain-mexico-overview-and-resources#*
6. *https://melissainstitute.org/wp-content/uploads/2020/06/Ervin-Staub-2018.pdf*
7. *https://phr.org/our-work/resources/forced-into-danger/*
8. *https://www.psychologytoday.com/intl/blog/dangerous-ideas/202204/jenifer-wolf-williams-psychological-support-migrants*
9. *https://www.refugeesinternational.org/yael-schacher*
10. *https://rollcall.com/2022/02/18/supreme-court-to-review-remain-in-mexico-policy-revival/*
11. *https://theintercept.com/2022/03/02/remain-in-mexico-asylum-biden-mpp-supreme-court/*
12. *https://www.theyoungcenter.org/*
13. *Staub, E. (2009). The roots of evil - the origins of genocide and other group violence. Cambridge Cambridge University Press.*

Dr. Kessler is a Member of the Physicians for Human Rights' Asylum Network, a Board Member of Doctors for Global Health, and Pastor in the Evangelical Lutheran Church in America.

The Intersection of Mental Health, Public Health, and Solitary Confinement

By: Mariposa McCall, MD

I chose psychiatry as a specialty in 1999 because the field promoted a holistic approach to care via the bio-psycho-social model. This model in my eyes could consider and address the social determinants of health (SDOH) such as poverty, violence, food and housing insecurity, under and unemployment, poor education, incarceration, language barriers, limited to no access to care, racism, immigration, discrimination. Along the way, I added to this lens, political, spiritual, and ecological dimensions to better capture people's realities. I have known from the beginning of my career that recovery treatment involves more than pills, that listening and compassionate action requires partnering with our patients to address these SDOH elements that contribute to distress and advocating with them as they empowered themselves in their recovery. I personally have found that including advocacy in treatment plans has helped me stay focus on the individual needs of each person and enriched my understanding of the complexities of their existences. For our patients, I believe co-advocacy has nurtured hope, solidarity, and improved outcomes.

This model in dealing with SDOH became more significant to me while I was working at California's San Quentin State Prison from 2010 to 2011, at Pelican Bay State Prison from 2014 to 2016, and then in 2019 as an expert witness for the CA Attorney General reviewing conditions and mental health care in three private California immigrant detention centers. I quickly learned that the conditions of confinement exemplified how SDOH were more pronounced in these institutions. Of the lessons I learned and things I witnessed behind those walls, one particular SDOH that stands out to me above all was a particular housing designation that is called the "prison within the prison," the "hole", or solitary confinement (SC). SC is an often overlooked preventable risk factor for illness and worsening health.

A LITTLE HISTORY

In the late 1780s, social and prison reformers promoted isolation as a humane alternative to existing corporal punishment. They believed that the silence in solitary cells would allow the prisoners to reflect on their transgressions, lead to moral and spiritual reform, and induce penitence. It soon became apparent that this practice was causing more harm than good as prisoners were hallucinating, becoming depressed, anxious, panicky, apathetic, agitated, confused, delusional, and harming themselves. By 1890, this well intended practice fell out of favor in penal institutions. As incarceration increased and overcrowding breeded violence, SC re-emerged as an option to manage the volatility within prisons, and its misuse has grown since the 1970s (1).

WHAT EXACTLY IS SOLITARY CONFINEMENT (SC)?

SC is a form of segregation where incarcerated individuals are separated from the general population for varied reasons for 22 to 24 hours a day for days, weeks, months, years, and even decades. One or two people are locked in a usually windowless, continuously lit, 8–by–10 foot cell. These spaces are usually made of concrete, with a concrete bed, non–moveable stool, and a toilet. Metal doors may have thin slits for custody to see in but give little view out. If custodial staffing is adequate, inmates may be allowed to shower 2-3 times a week and may get an hour to exercise alone in a cage only slightly bigger than their cell, often exposed to the elements. Meals are eaten in the cell. There is usually no access to educational classes, job training, work, drug treatment, religious services, or rehabilitative programming. Inmates are allowed very limited personal property. Access to medical and mental health care is often more difficult. Family visits and calls are limited and only for emergencies, as in the case of deaths.

HOW MANY PEOPLE ARE HELD IN SC, AND FOR HOW LONG?

Because solitary confinement goes by many different names ("security housing units", "restricted housing", "administrative/protective/disciplinary segregation", "isolation") it has been difficult to say how many people are in this highly restrictive placement. According to the Bureau of Justice Statistics, from 2011-2012, 20% of people in U.S. jails and prisons spent time in SC during their incarceration (2). In November 2016, the Yale Law School and the Associations of State Correctional Administrators researchers found that in 48 jurisdictions (the Federal Bureau of Prisons, 45 states, the District of Columbia, and the Virgin Islands) there were roughly 67,442 in SC, with percentage of federal and state prison populations ranging from 1-28% (3). These numbers do not include juvenile facilities, immigration and military detention centers, jails, or all federal and state prisons. Per the 41 jurisdictions that provided time spent in SC, 29% of population in SC were there for 1-3 months, 29% for 3-12 months, 24% for > 1 year, 11% for >3 years, and in some jurisdictions, 5.4% > 6 years (3). One of the private immigrant detention facilities I reviewed in 2019 had 32% of its 778 detainees in SC for more than 15 days (4). The vague justification for the longest duration, 310 days, was given facility-initiated placement"; "horseplaying" got another SC stay for 248 days and counting (4). Mr. Albert Woodfox spent 43 years (imagine!) in SC in Angola State Prison after he and two other Black Panther party members were accused of murdering a prison guard in 1972. His conviction was overturned three times, and in 2015 the courts ordered that he be released immediately at the age of 69 (5).

In October 2011, the United Nations Special Rapporteur on torture, Juan E. Mendez, called for an absolute ban on solitary confinement lasting more than 15 days: "Considering the severe mental pain or suffering solitary confinement may cause, it can amount to torture or cruel, inhuman or degrading treatment or punishment when used as a punishment, during pre-trial detention, indefinitely or for a prolonged period, for persons with mental disabilities or juveniles" (6). This statement was consistent with Rule 43 of the 2015 revised 122 Mandela Rules of the United Nations Standard Minimum Rules on the Treatment of Prisoners which prohibits both indefinite solitary confinement and prolonged solitary confinement (defined as lasting more

than 15 days) (7).

WHAT IS THE HEALTH IMPACT OF SC?

There is surmounting evidence that SC- with its cocktail of sensory deprivation and overload, social disconnection, and idleness- harms mental and physical health of those exposed to it. Those without preexisting mental illness may experience a deterioration in mental health, and those with mental health conditions often decompensate and cycle from suicide watch to psychiatric hospital back to SC.

Placing someone in an extreme environment such as SC taxes the body and psyche, and often overwhelms a person's capacity to cope. Isolation such as that endured in SC is associated with a 26 percent increased risk of premature death, largely from a stress response that produces significant cortisol levels, increased blood pressure, and inflammation. Chronic stress damages the hippocampus which impacts memory, spatial orientation, learning, and emotion processing, while increasing activity of the amygdala which mediates fear and anxiety (8,9,10).

Individual responses to segregation vary. Some inmates decompensate quicker than others, some are impacted more than others, but no one leaves unscathed. Within days of being placed in SC, possible complications include disruption of the sleep-wake cycle, headaches, eyesight deterioration, diaphoresis, dizziness, palpitations, headaches, muscle deconditioning, digestive problems, joint pains, fatigue, anxiety, panic, depression, anger, impulsivity, paranoia, hallucinations, dissociations, obsessions, compulsive behaviors, inability to focus, confusion, disorientation, disorganized thinking, trouble shifting attention, rigid thinking, trouble processing information, hyper-sensitivity to stimuli, heightened startle response, hypervigilance, hopelessness, helplessness, and violence to self and others (11,12,13,14,15,16,17,18). Furthermore, SC can be re-traumatizing for a population which is already disproportionately burdened by previous trauma.

Some of these effects may persist after release from SC. In 2017, Stanford University's Human Rights in Trauma Mental Health Lab released a consultative report detailing the mental health consequences following release from SC in California that stated that those who had been out of SC for an average of 14 months were endorsing "emotional suppression and dysregulation", "significant alterations in cognition and perception", "problems with attention, concentration, memory", "pervasive hypervigilance, worry, nervousness", "chronically feeling under threat or danger", "sensory sensitivity", "distress, anxiety, paranoia, irritability", "overwhelmed"; "...the majority...expressed a need for mental health care due to the psychological harm they endured in SC" but were hesitant to request MH services in prison due to their distrust of the system (19).

I have treated individuals in the community years after their release from prison. These individuals continue to suffer from this kind of SDOH. SC is seen and experienced as a deliberate attempt and tool to break a person. Every person I have spoken with who has been in SC has spoken of the intense fear of losing their sanity and of the tremendous energies it takes to not deteriorate into "madness". Mr. Woodfox has spoken of the fear he has endured "adapting to the painfulness…There is a part of me that is gone…I had to sacrifice that part in order to survive." (5). Neuroscientist Matthew Lieberman, director of the UCLA Social Cognitive Neurocognitive Laboratory, through his research using fMRI has found that the same neural and neurochemical processes caused by physical pain are invoked by social isolation (20,21,22). It is a painful existence.

Human connection is a universal essential basic human need (23). SC strains and breaks connections with families and friends, weakening one of the most important protective factors we know against suicide and one of the most vital ingredients for health. Human beings are social creatures. We define ourselves largely through our relationships to others. Research has shown that "depriving people of normal social contact and meaningful social interaction over long periods of time can damage or distort their social identities, destabilize their sense of self, and for some, destroy their ability to function normally in free society... Prolonged social deprivation…is destabilizing in part because it deprives persons of the opportunity to ground their thoughts and emotions in a meaningful social context- to know what they feel and whether those feelings are appropriate...the human brain is literally 'wired to connect' to others...social exclusion is not only 'painful in itself,' but also 'undermines people's sense of belonging, control, self-esteem, and meaningfulness, reduces prosocial behavior, and impairs self-regulation'...social exclusion can result in ...emotional numbing, reduced empathy, cognitive inflexibility, lethargy, and an absence of meaningful thought." (24). It is, therefore, not surprising that over 50 % of suicides in carceral institutions occur in this setting (16,17). In 2014, 79% of suicides in California prisons occurred in isolation units (1). Additionally, people in SC have the highest rates of self-injurious behaviors (16,17,25).

WHO GETS PLACED IN SC?

While working in California prisons, I was told that people confined to SC had

"earned their way there" and that they were "the worst of the worst". The reality is that this highly restrictive housing that was supposed to be used as a last resort after exhausting alternatives has become the management tool of choice for all sorts of disturbances and inconveniences. There is an extensive laundry list of possible non-violent disciplinary infractions that could land a person in SC, such as: disobeying an order, having an extra piece of clothing or food not authorized, having too many stamps, refusing a cellmate, talking back, indecent exposure, misusing medications, gambling, being "unsanitary." In a private detention center I reviewed in 2019, there were 16 detainees in SC for "engaging in or inciting a group demonstration" (i.e., hunger strike) to protest the conditions of their confinement (4). Ethnic subpopulation members who are impacted by racism, implicit biases, and deemed to be a potential threat, despite not broken any rule or having had a violent offense-are placed here. Not only are people of color disproportionately represented in the criminal system, they are placed in SC at much higher rates (26,27). Additionally, those vulnerable to victimization such as the elderly, those with intellectual or mental or physical disabilities, LGBTQ persons, those who have "snitched" on others, are sent to SC-allegedly for their own protection, and at a great cost. LGBTQ persons are more likely to be placed in SC (28). People with disabilities and other vulnerable groups need to be provid-

ed accommodations with equal access to all programs, services, and activities that are available in the general population (GP) and, not in essence, punished for their conditions or who they are. SC should never be a substitute to having adequate staffing, quality treatment, or trauma-informed practices.

According to a 2017 Department of Justice report, half of people in state prisons had either current "serious psychological distress" or a history of mental health problems (29). Those with mental illness often struggle to follow the rules of confinement, leading to write- ups that extend to SC. The 1995 federal class action lawsuit - Madrid v. Gomez, decided by Judge Thelton Henderson, found that Pelican Bay State Prison was unconstitutionally housing those with mental illness in security housing units as it violated the Eighth Amendment's ban on "cruel and unusual punishment". Judge Henderson wrote: "For these inmates, placing them in [the segregated housing unit] is the mental equivalent of putting an asthmatic in a place with little air to breathe. The risk is high enough, and the consequences serious enough that we have no hesitancy in finding that risk is plainly unreasonable" (30). In 2015, Justice Kennedy reviewed the literature on SC causing mental illness, and "criticized the widespread use of solitary confinement in American prison" (32). Judge Kennedy stated "Research still confirms what this Court suggested over a century ago: Years on end of near-total isolation exacts a terrible price" (32). Unfortunately, despite these condemning rulings against SC, across the country people with and without mental health conditions continue to be placed in SC, increasing risk for bad health outcomes.

The existence of many potential nonviolent reasons that someone can land in SC, creates a culture of fear: there is an elusive threat and a breeding ground for injustices. Custodial officers have tremendous discretionary power to determine what constitutes a rules violation. "When you have very little oversight and little controls on systems of extreme punishment, what you see is discrimination and animus works its way in," said Amy Fettig, the senior staff counsel for the ACLU's National Prison Project (33). Detained immigrants have limited or no recourse for unjust placement.

WHAT PROTECTIONS ARE IN PLACE FOR THE PRACTICE OF SC?

Due to some recognition of the harsh, dehumanizing conditions of SC by prison, jail, and detention center administrators, policies and regulations have been written to mitigate these harms. Some directives include pre-SC placement screening by a health care professional (HCP), usually an LVN or RN with possible MH training. Screening can determine whether or not they are placed in SC. If they are cleared for SC, screening can also determine whether they will have: daily wellness checks by an HCP (unfortunately, a brief non-confidential cell-front interaction), custodial safety checks, weekly or monthly mental health (MH) visits for those identified to have MH conditions, periodic MH visits with those not on the MH "caseload", or weekly multidisciplinary case reviews. MH providers cana advocate for transfer out of SC for patients who have decompensated during SC. Unfortunately, I have witnessed that for a myriad of reason such mandates have not been followed, are inadequate, or have not provided needed relief.

In my view, HCPs should not be declaring anyone "cleared" for this type of high-risk containment, given what we know about its harms. To do so gives approval and legitimacy to the practice. "First do no harm." The Physicians for Human Rights (PHR) Dual Loyalty Guide states that "doctors should not collude in moves to segregate or restrict the movement of prisoners except on purely medical grounds, and they should not certify a prisoner as being fit for disciplinary isolation or any other form of punishment...Doctors should not certify fitness for isolation" (34). The National Commission on Correctional Health (NCCHC) takes a similar stand in its 2016 SC position statement: "Health staff must not be involved in determining whether adults or juveniles are physically or psychologically able to be placed in isolation" (35).

FINAL WORDS ON ELIMINATING THIS SDOH

Recognizing the preventable harms from SC placement that occur even with a few days, it is our clinical obligation to our patients and our social responsibility to all incarcerated people to challenge this practice. Some feel that it is not their job to call out human rights violations, or injustices. Some feel powerless, or fear the real threat of retaliation if they were to speak up against policies or actions that harm patients. "Individual practitioners should not have to wrestle alone with a prison practice that violates human rights norms. Their professional organizations should help them…organizations...should use their institutional authority to press for a nationwide rethinking of the use of isolation" (36).

Considering that 95% of those incarcerated will be released back to the community, bringing with them the negative health consequences of their confinement, the conditions and traumas they face while incarcerated should concern us all. Aside from the fact that it is 3 times more expensive to house someone in SC versus general population, SC is at odds with the goal of rehabilitation or the facilitation of social reintegration (18). Social psychologist Craig Haney has explained that "in order to survive the experience, many people must adapt to it in ways that deny fundamental aspects of their humanity: Solitary confinement is a socially pathological environment that forces long term inhabitants to develop their own socially pathological adaptations in order to function and survive" (37). In a 2015 Washington Post Op-Ed piece, President Obama wrote: "How can we subject prisoners to unnecessary solitary confinement, knowing its effects, and then expect them to return to our communities as whole people? It doesn't make us safer. It's an affront to our common humanity." (38). There is much more evidence that SC promotes harms than safety. This experiment must be halted. We urgently need more humane strategies that maintain institutional security while protecting human rights and health.

References:

1. Reiter K. 23/7: Pelican Bay Prison and the Rise of Long-Term Solitary Confinement. Yale University Press, 2016.

2. Skibba R. Solitary Confinement Screws Up the Brains of Prisoners. Newsweek. April 18, 2017.

3. Aiming to Reduce Time-In-Cell: Correctional Administrators and Yale Law School's Liman Program Release New Report on Efforts to Reduce the Use of Isolation in State and Federal Prisons.

Association of State Correctional Administrators, The Arthur Liman Public Interest Program, Yale Law School, 2016. https://assets.documentcloud.org › documents › Aiming-t.
4. The California Department of Justice's Review of Immigration Detention in California. Office of the Attorney General, California Department of Justice. 2020 second report on CA immigration detention, https://oag.ca.gov/publications#immigration-detention.
5. Aviv R. How Albert Woodfox survived solitary. The New Yorker. January 8, 2017. https://www.newyorker.com/magazine/2017/01/16/how-albert-woodfox-survived-solitary?utm_source=onsite-share&utm_medium=email&utm_campaign=onsite-share&utm_brand=the-new-yorker
6. Solitary confinement should be banned in most cases, UN expert says. United Nations. News release. October 18, 2011. https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-say
7. United Nations Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules). U.N. ESC Committee on Crime Prevention and Criminal Justice, 24th Sess., U.N. Doc. E/CN.15/2015/L.6/Rev.1 (May 22, 2015) [hereinafter Nelson Mandela Rules], http://www.un.org/press/en/2015/ga11745.doc.htm
8. Holt-Lunstad J, Smith TB, Baker M. et al. Loneliness and Social Isolation as Risk Factors for Mortality: a Meta-Analytic Review. Perspect Psychol Sci. 2015 Mar;10(2):227-237.
9. Kim EJ, Pellman B, Kim JJ. Stress effects on hippocampus: a critical review. Learn Mem. 2015 Sep; 22(9): 411–416.
10. Blanco-Suarez E. The effects of solitary confinement on the brain. Psychology Today. https://www.psychologytoday.com/us/blog/brain-chemistry/201902/the-effects-solitary-confinement-the-brain
11. Ahalt C, Rothman A, Williams BA. Examining the role of healthcare professionals in the use of solitary confinement. BMJ. October 24, 2017; 359.
12. Ahalt C, Haney C, Rios S, et al. Reducing the use and impact of solitary confinement in corrections. Int J Prison Health. 2017; 13 (1): 41-48.
13. Ahalt C, Williams BA. Reforming Solitary -Confinement Policy- Heeding a Presidential Call to Action. N Engl J Med. 2016; 374 (18): 1704-1706.
14. Appelbaum KL. American Psychiatry Should Join the Call to Abolish Solitary Confinement. J Am Acad Psychiatry Law. 2015; 43 (4): 406-415.
14. Cloud DH, Drucker E, Browne A, et al. Public Health and Solitary Confinement in the United States. Am J Public Health. 2015; 105 (1): 18-26.
15. Gallagher S. The cruel and unusual phenomenology of solitary confinement. Frontiers in Psychology. 2014: 5:585.
16. Kupers TA. Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. Wiley, John & Sons; 1999.
17. Kupers TA. Solitary: The Inside Story of Supermax Isolation and How We Can Abolish It. University of California Press; 2017.
18. James K, Vanko E. The Impacts on Solitary Confinement. Vera Institute of Justice; 2021.
19. Brunner J, Joseff K, Matlow R, et al. Mental Health Consequences Following Release from Long-Term Solitary Confinement in California Consultative Report Prepared for the Center for Constitutional Rights. Human Rights in Trauma Mental Health Lab, Stanford University; 2017.
20. Jones OD, Marois R, Farah MJ, Greely HT. Law and Neuroscience. J Neurosci. 2013; 33(45): 17624–17630.
21. Morse S. Criminal law and common sense: an essay on the perils and promise of neuroscience. Marquette Law Review. 2015;99 (1): 39–74.
22. Murphy E. Neuroscience and the civil/criminal Daubert divide. Fordham Law Review. 2016; 85(2): 619, 629.
23. Baumeister RF, Leary MR. The Need to Belong: Desire for Interpersonal Attachment as a Fundamental Human Need. Psychology Bulletin. 1995; 117 (3).
24. Haney C. Restricting the Use of Solitary Confinement. Annual Review of Criminology. 2018, 1(1): 285-310.
25. Kaba F, Lewis A, Glowa-Kollisch S, et al. Solitary confinement and risk of self-harm among jail inmates. Am J Public Health. 2014; 104(3):442-447.
26. Lantigua-Williams J. The link between race and solitary confinement. The Atlantic. December 5, 2016.
27. Flagg A, Tatusian A, Thompson C. Who's in Solitary Confinement? The Marshall Project. Nov. 30, 2016. https:///www.themarshallproject.org/2016/11/30/1-new/reportgives/the/most/detailed-breakdown-yet-of-how-isoaltion-issued-in-u-s-prisons.
28. Beck AJ. Use of Restrictive Housing in U.S. Prisons and Jails, 2011-2012. United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2015. https://perma.cc/YL9S-7B98.
29. Bronson J, Berzofsky M. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics; 2017. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf.
30. Madrid v. Gomez, 889 F. Supp. 1146, 1265 (N.D. California 1995).
31. Davis v. Ayala, 135 S. Ct. 2187, 2208-2210 (2015).
32. Ford M. Justice Kennedy Denounces Solitary Confinement. The Atlantic. June 18, 2015.
33. Eichelberger E. How racist is solitary confinement? A New York Study of 45,000 inmates shows that blacks and Hispanics are more likely than whites to be punished with solitary confinement, and less likely to receive diagnoses of mental illness. The Intercept. July 16, 2015.
34. Dual Loyalty, Global. Dual loyalty and human rights in health professional practice: proposed guidelines and institutional mechanisms. Physicians for Human Rights. March 1, 2003.
35. Solitary Confinement (isolation). National Commission on Correctional Health Care. April 2016.
36. Fellner J, Metzer J. Solitary confinement and mental illness in U.S. Prisons: a challenge for medical ethics. J Am Acad Psychiatry Law. 2010; 38(1):104-8
37. Haney C. The psychological effects of solitary confinement: a systematic critique. Crime and Justice. 2018;47. http://safealternativestosegregation.vera.org
38. Obama B. Why we must rethink solitary confinement. The Washington Post. January 25, 2016. https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016.

Dr. Mariposa McCall is Board Certified Psychiatrist working in Martinez, CA.

Horseshoe Farm Fellowship: A Reflection

By: Carlye Goldenberg

As we sat across from each other in his low-income housing unit in Greensboro, Alabama, "Will" had a somber look on his face. Visits with my seventy-year-old health partner–who battles glaucoma, high blood pressure, anxiety, and depression–are often the highlight of my week. While he struggles with loneliness and motivation to improve his lifestyle, Will is one of the most genuine, gracious, warm-hearted people I have ever met. For example, walking out of appointments or wandering through the grocery store, Will tells everyone we encounter to "stay blessed and be safe," resulting in a smile from each recipient.

Some days, we chat about his passion for gardening and current events. Other times, we silently watch television as he answers any of my questions that may arise. Yet, on this day, I could see he was struggling. I gently asked if something was going on; he explained that an acquaintance of his, someone he had only met a couple of times, had killed himself. Will was confused: this man was a doctor and a leader in his community; he had a family and seemed to have his life figured out. We began discussing how appearances often do not mirror reality and how internal struggles may not match outward actions. Will expressed that he does not know how he would have made it through this pandemic without his support from Horseshoe Farm.

After months of talking about everything but his health, these conversations led to us openly discussing his mental health. While the bulk of our relationship has not changed, I have developed a deeper appreciation for the power and impact of companionship, consistency, and time. Not every visit is life-changing, but that day, I realized that a compilation of hour-long visits might be.

Genuine relationships are not built in one day or a couple of weeks. For many of my health partners at Horseshoe, months passed before we began discussing or developing health goals. But for each individual, we eventually transcended a critical point–whether it was when "Tina" started saying, "I love you, Carlye," before hanging up the phone, or when "Ronnie" began calling to let me know she was agitated and needed someone to listen. Now eleven months into the fellowship, I am supporting specific goals with each health partner and can better guage each person's state of change or conviction.

While I recognize that time is one of the most valuable contributions I can provide to individuals, I have also learned that considerable time is imperative to gaining cultural competence in a new community. The southern United States has many unique cultural attributes that differ from my midwestern upbringing, such as endless invitations to potlucks, greetings from everyone (whether I know them or not) on the street, and relentless hospitality and courtesy. One of the most distinctive differences I have encountered has been the significance of religion in daily life.

This dissimilarity became evident as I sat next to "Tina" in a rocking chair on her peeling porch. A tear rolled down her face as she held my hand tighter. Two weeks before I met Tina, her grandson and great-grandson were tragically killed when a tree fell on their mobile home. Grief drove her into a period of acute depression and intensified her physical discomfort. The first few months of our relationship consisted of many tears and expressions of unbearable pain.

I continued to visit twice a week, often listening to stories about her deceased grandchildren and creating a safe space for her to process her feelings. Recently, she has committed herself to prayer and religious observance, reciting Bible verses each morning and annotating a personal copy of The King James Version throughout restless nights. One day, Tina proudly disclosed that she had recorded more than five hundred hours of Bible study. She explained that while she would never understand why her beautiful grandchildren were taken from this world too early, her daily prayers led her to trust that God had a plan.

During a period when Tina felt helpless, Bible study provided her with a renewed sense of purpose, and religion guided her understanding of hardship and struggle. Living and working within this tight-knit community has taught me that, in general, faith shapes the ethical framework of many Greensboro residents. I have been taking small steps to understand this importance, including chatting with a local pastor over pie and attending a multiethnic service with my neighbors. Through experiencing the weekly spiritual rituals of so many in Greensboro, I have developed a better understanding of why the individuals I work with place so much faith in their beliefs: religious communities provide purpose, structure, and meaning. And for many, such as Tina, religion lends possible answers to complicated questions. By engaging more deeply with community-held activities and values, I can better empathize with my neighbors and support their health goals.

Ultimately, listening and working toward common goals has allowed me to connect with individuals who are culturally, politically, and religiously different from me, and many of these relationships will last well beyond my time in Greensboro. This year of service has shaped how I want to approach my future work as a physician: I want to spend considerable time forming relationships with underserved patients–those overlooked or under supported by our current healthcare system–and practice patient-centered care. To do this, I will need to gain an understanding of the various social, environmental, political, and economic factors which impact their health and community. This is not a quick process. Yet, I am now more motivated than ever to commit the necessary time it will take to understand what my role can be in working at the intersection of community health and medicine.

Carlye Goldenberg is a graduate of the University of Michigan where she earned a B.S. in Biology, Health and Society. She is currently a Community Health Fellow at Project Horseshoe Farm and will be attending the University of Missouri School of Medicine in the fall.

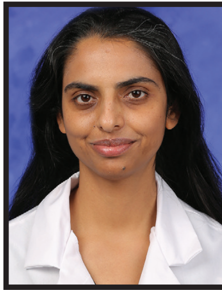
From Project Horseshoe Farm Founder and Director, John Dorsey, MD:

Project Horseshoe Farm (www.projecthsf.org) is a nonprofit organization with sites in Greensboro, Alabama, Marion, Alabama, and Pomona, California. The organization works with top recent college graduates from around the country for a year of service, learning, and community health leadership development (the Horseshoe Farm Fellowship). Carlye's essay describes her experience in the "Health Partners" program. In the program, each Fellow works over the course of the year with approximately 6-10 adults, including seniors, adults living with mental illness, and other isolated or vulnerable adults in the community. Fellows provide home visits, help with local transportation, accompany their health partners to doctor's appointments, encourage healthier behaviors, help their health partners navigate health and social services systems, and most importantly provide a consistent and caring relationship. In addition to their work with health partners, Fellows provide small group academic support and mentorship to children in local elementary schools, provide volunteer support to local community centers and senior centers, and provide relationship-based support to residents at local nursing homes and supported housing programs. Since the Fellowship launch in 2009 through our incoming 2022-23 class, approximately 170 Fellows will have participated in the program.

To learn more about Project Horseshoe Farm, go to: http://www.projecthsf.org.

A Pandemic of Mistrust

By: Ramnarine Boodoo, MBBS, Elisabeth Kunkel, MD, Amandeep Bhandal, MD, and Kyra Chester-Paul, BA



A sizeable percentage of the U.S. population currently believes, without evidence, that the 2020 presidential election was fraudulent, and that the current President does not deserve to lead the American people [1]. This belief triggered a coup attempt against the executive branch of the federal government on 01/06/2021 [2]. Perhaps even more disturbingly, it triggered the introduction of state laws designed to subvert the electoral process of this country [3, 4]. Unfortunately, this belief shows no sign of abating [1].

How did so many Americans, residing in the wealthiest nation on the planet, many receiving a "first world" education, enjoying an enshrined right to freedom of speech, and exposed to a free news media, develop what might be described as a delusion of national proportions? In this article, we hypothesize that the genesis of this is a construct familiar to all mental health providers: trust.

Anyone who provides care knows that without trust, their work becomes significantly more difficult. Trust was posited as the first stage of psychosocial development by Erik Erikson [5]. In fact, trust has been described as the foundation of all interpersonal relationships [6]. But is the concept of trust between individuals similar to trust on a societal level? We believe it is, and that the mechanism of social trust is the social contract.

The concept of the social contract can be traced back to the European Age of Enlightenment [7], or even further [8]. It generally stipulates that each individual, either explicitly or implicitly, gives up a measure of freedom and material wealth to the state. In return they receive good social order, including laws and the enforcement of laws. However, for any contract to work, especially over the long term, its provisions must be adhered to. Unfortunately, it seems that the social contract of the U.S. has been eroded. A small sampling of ways this has happened include:

1. Rising income inequality
   • According to the U.S. Federal Reserve, the 3rd quarter of 2021 saw the top 1% of the U.S. wealth percentile controlling $43.94 trillion in wealth, while the bottom 50% held only $3.42 trillion [9].
2. Decreasing socioeconomic mobility
   • Since 1980, socioeconomic mobility (the movement of individuals from one social or economic class to another) in the U.S. has been declining significantly [10].
3. An unfair justice system
   • Being White allows for significant leniency in sentencing [11].
   • The Sackler family and Purdue Pharma, who knowingly contributed to thousands of opioid deaths through the marketing of their products [12], have yet to be criminally charged for wrongdoing [13].
   • Social media companies such as Facebook (now Meta), despite knowing that their products cause grave social and individual harm [14], cannot be held accountable due to antiquated laws [15].

What has been shown throughout history is that when a social contract is broken, social unrest results [16]. Regarding the Capitol attack, it seems that the former President was able to capitalize on mistrust by claiming that the 2020 election was rigged [17]. If one has no trust to begin with, why shouldn't one believe that the institutions failed, and that their side actually won?

For healthcare providers, perhaps nowhere is the effect of mistrust in our institutions more clearly demonstrated than in the mistrust of medical science. According to a recent Pew Research study, "Overall, 29% of U.S. adults say they have a great deal of confidence in medical scientists to act in the best interests of the public, down from 40% who said this in November 2020" [18]. Additionally, a recently published study in The Lancet noted "Measures of trust in the government and interpersonal trust, as well as less government corruption, had larger, statistically significant associations with lower (COVID-19) standardised infection rates. High levels of government and interpersonal trust, as well as less government corruption, were also associated with higher COVID-19 vaccine coverage among middle-income and high-income countries where vaccine availability was more widespread" [19].

So how is this state of affairs to be remedied? We believe that the only way to significantly correct course is to restore trust by fulfilling the social contract. The essence of doing this is to treat each other fairly—on a national scale. Action steps can include:

1. Addressing the influence of money on political candidates and elected leaders.
   • Scrutinizing political lobbying efforts and empowering ethics watchdogs.
2. Eliminating impunity by reforming a multi-tiered justice system.
   • Eliminating cash bail.
   • Investing in public defenders and legal aid services.
   • Ensuring law enforcement is held accountable for misconduct.
   • Decreasing racial disparities in sentencing.
   • Bringing criminal charges against those who have endangered the public or defrauded the government.
   • Updating laws related to social media and the internet, particularly section 230 of the Communications Decency Act.

• Creating more diversion programs, which offer mental health and addiction services as alternatives to incarceration.

3. Decreasing wealth inequality.
   • Taxing the ultra-wealthy.
   • Implementing a single-payer healthcare system.
4. Increasing social mobility.
   • Funding schools from a federal level, so that schools in low-income districts are not under-funded.
   • Affirmative action programs.
5. Eliminating barriers to electoral participation.
   • Passing new legislation ensuring equitable access to voting and restricting partisan gerrymandering.

Only by creating a situation where the population feels protected by its government, and not exploited or ignored by it, can we reduce the risk of events like the Capitol riot being repeated. Of course, it remains to be seen whether any of the changes outlined will actually be implemented. We may already be firmly in the grip of a negative feedback loop, where any attempt at reform is quickly and quietly quashed by the forces that benefit from the status quo. All empires rise and fall. The only real question is when, and how.

References

1. Dickson, C. (2021, August 4). Poll: Two-thirds of Republicans still think the 2020 election was rigged. Yahoo News - Latest News & Headlines. https://news.yahoo.com/poll-two-thirds-of-republicans-still-think-the-2020-election-was-rigged-165934695.html?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_re

2. They believe in Trump's 'Big lie.' here's why it's been so hard to dispel. (2022, January 5). NPR.org. https://www.npr.org/2022/01/05/1070362852/trump-big-lie-election-jan-6-families

3. Voting laws roundup: December 2021. (2021, December 21). Brennan Center for Justice. https://www.brennancenter.org/our-work/research-reports/voting-laws-roundup-december-2021

4. Wilder, W. The Election Sabotage Scheme and How Congress Can Stop It. (2021, November 18). Brennan Center for Justice.

5. Erikson's stages of psychosocial development - StatPearls - NCBI bookshelf. (2020, November 22). National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/books/NBK556096/

6. Simpson, J. A. (2007). Psychological foundations of trust. Current Directions in Psychological Science, 16(5), 264-268. https://doi.org/10.1111/j.1467-8721.2007.00517.x

7. J. W. Gough, The Social Contract (Oxford: Clarendon Press, 1936), pp. 2–3.

8. Mbah, A. A. (2016). The Transformation of Man from State of Nature to Civil Society: A Philosophical Investigation. International Journal of Arts Humanities and Social Sciences, 1(2). www.ijahss.com

9. The Fed - Table: Distribution of household wealth in the U.S. since 1989. (n.d.). Federal Reserve Board. https://www.federalreserve.gov/releases/z1/dataviz/dfa/distribute/table/

10. Aaronson, D., & Mazumder, B. (2008). Intergenerational Economic Mobility in the United States, 1940 to 2000. Journal of Human Resources 43(1), 139-172. doi:10.1353/jhr.2008.0008.

11. Lopez, G. (2017, November 17). Report: Black men get longer sentences for the same federal crime as white men. Vox. https://www.vox.com/identities/2017/11/17/16668770/us-sentencing-commission-race-booker

12. Justice Department announces global resolution of criminal and civil investigations with opioid manufacturer Purdue Pharma and civil settlement with members of the Sackler family. (2021, April 21). U.S. Department of Justice. https://www.justice.gov/opa/pr/justice-department-announces-global-resolution-criminal-and-civil-investigations-opioid

13. Wolf, Z. B. (2021, September 3). Analysis: The worst drug dealers in history are getting away with billions. CNN. https://www.cnn.com/2021/09/02/politics/what-matters-sackler-opioid-purdue-pharma/index.html

14. Here are 4 key points from the Facebook whistleblower's testimony on Capitol Hill. (2021, October 5). NPR.org. https://www.npr.org/2021/10/05/1043377310/facebook-whistleblower-frances-haugen-congress

15. The Justice Department unveils proposed section 230 legislation. (2020, September 23). U.S. Department of Justice. https://www.justice.gov/opa/pr/justice-department-unveils-proposed-section-230-legislation

16. A broken social contract? (2011, September 22). Harvard Political Review. https://harvardpolitics.com/londons-other-half-a-broken-social-contract/

17. Disinformation fuels distrust and even violence at all levels of government. (2021, March 1). NPR.org. https://www.npr.org/2021/03/01/971436680/from-the-u-s-capitol-to-local-governments-disinformation-disrupts

18. Americans' trust in scientists, other groups declines. (2022, February 15). Pew Research Center Science & Society. https://www.pewresearch.org/science/2022/02/15/americans-trust-in-scientists-other-groups-declines/

19. COVID-19 National Preparedness Collaborators. (2022). Pandemic preparedness and COVID-19: an exploratory analysis of infection and fatality rates, and contextual factors associated with preparedness in 177 countries, from Jan 1, 2020, to Sept 30, 2021. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00172-6/fulltext#%20

Dr. Boodoo is Assistant Professor, Child and Adolescent Psychiatry, Pennsylvania State University College of Medicine. Dr. Kunkel is Professor, Department of Psychiatry and Behavioral Health, and The Joyce D. Kales University Chair in Community Psychiatry, Pennsylvania State University College of Medicine. Dr. Bhandal is Fellow, Child and Adolescent Psychiatry, Pennsylvania State University College of Medicine. Ms. Chester-Paul is a Medical Student at Pennsylvania State University College of Medicine.

Community Updates

CONGRATULATIONS TO AACP'S RECENTLY ELECTED OFFICERS AND BOARD MEMBERS
President: Dr. Altha Stewart
Vice President: Dr. Peter Chen
Secretary: Dr. Ann Hackman
Treasurer: Dr. Rob Cotes
Newly Elected ECP Rep: Dr. Jessica Isom
Newly Elected ECP Rep: Dr. Lucy Ogbu-Nwobodo
Newly Elected At-Large Member: Dr. Kim Gordon Achebe
Newly Elected At-Large Member: Dr. Matthew Goldman
Newly Elected At-Large Member: Dr. Rachel Talley
Re-Elected At-Large Member: Dr. Laurel Blackman
Re-Elected At-Large Member: Dr. Sarah Vinson

UPCOMING MEETINGS
AACP Board Meeting:
Sunday, May 22, 9:00 am-5:00 pm
Loews Hotel: St. Tammany Room, 9th Floor; New Orleans
Open to all members.

AACP Membership Meeting:
Sunday, May 22, 5:30-7:00 pm
Loews Hotel: Feliciana Room, 10th Floor; New Orleans
Remote access will be available via Zoom.

AACP Members Social:
Sunday, May 22, 7:00-9:00 pm
Loews Hotel: Piazza Room; New Orleans
Guests welcome!

SMART TOOL
Heard about AACP's SMART Tool? "SMART" stands for Self-Assessment for Modification of Anti-Racism Tool. Now you can sign up for SMART Office Hours with co-creator Rachel Tally! Learn more about the tool here: AACP - SMART tool (communitypsychiatry.org).

UPCOMING APA ASSEMBLY MEETING
The APA Assembly will be meeting in New Orleans from Friday May 20th through Sunday May 22. Here are some of the Action Papers that will be discussed and voted on at that meeting:

- *Bolstering Services for Substance Use Disorders in Incarcerated Persons*
- *Improved Awareness of the Impact of Psychiatric Diagnoses and Treatments on Military Members*
- *Calling for a Subspecialty in Climate and Mental Health*
- *Devaluating the Greenhouse Gas Pollution from Specific Psychiatric Practices*
- *Strengthening Equivalent Pathways for Maintaining Board Certification*
- *Enhancing the Learning Experience about Jail and Prison Psychiatry in General Psychiatry Residency Programs*
- *Establishment of an Assembly Committee on Social Determinants of Mental Health*
- *Anti-Asian American and Pacific Islanders (AAPI) Discrimination and Media Representation of AAPI Communities*

Questions about how to write an Action Paper, or about how the APA Assembly works? reach out to AACP's liaison to the APA Assembly, Dr. Isabel Norian (belle_note@yahoo.com).

SPECIAL THANKS to resident-fellow member of the Board, Amy Gallop MD, for her assistance in the editing of this newsletter.

AND ONE MORE THING…
AACP will be welcoming a new Newsletter Editor soon! It's been an adventure serving as Editor these past several years, and I will be forever grateful to Michael Flaum for having taken a chance on me. My deepest thanks also to Frances, who has kept me together and brought every edition over the finish line. Thank you always to our former publisher Nancy; may she rest in peace. Thanks also to our many resident-fellow Board members who've assisted with editing along the way. Thank you to Liz Frye, who came before me, for sharing wisdom that helped get me started. Thanks most of all to AACP members who continue to give voice to things we need to be talking about. Keep it going!

In Loving Memory:
Robert Rabin

(d. Feb 28, 2022)

Who fought fiercely, body and soul, for Vieques, Puerto Rico.
Who welcomed AACP members as family.
Who introduced us to Vieques and its extraordinary people.
Who fought with every part of him to make life better for others.

you loved this land
you held it in your hands
you used your body
to protect it
your soul
to defend it
they couldn't move you
if they tried
the land will not
forget
you

To learn a about Robert and his advocacy for Vieques, Puerto Rico, check out these links.

Robert Rabin Siegal - Radio Vieques | #DefendPR - YouTube (2017)

Puerto Rico Vieques Island: Robert Rabin Bomb Range Impact - YouTube (2018)

Massachusetts native an unlikely leader for Puerto Rican anti-Navy protesters (latinamericanstudies.org) (2000)

Muere el activista y líder de Vieques, Robert 'Bob' Rabin – Ey Boricua (2022)

Longtime Vieques Activist Robert Rabin Dies in Puerto Rico – Repeating Islands (2022)

35 YEARS OF PRMS!

CONSIDER THE PROGRAM THAT PUTS PSYCHIATRISTS FIRST.

Before selecting a partner to protect you and your practice, make sure your carrier offers what we can:

NATIONAL PROGRAM
Comprehensive coverage to cover patients treated anywhere in the U.S.

COMMUNITY
Proud partner and sponsor of 40+ psychiatric organizations throughout the country.

POLICY BENEFITS
Telepsychiatry and forensic psychiatry coverage, and up to $150,000 medical license defense included at no additional cost.

FINANCIAL STABILITY
A+ Superior A.M. Best rating for FAIRCO®, insurance carrier for The Psychiatrists' Program®.

RISK MANAGEMENT EXPERTISE
State- and psychiatry-specific alerts, plus educational resources and CME programs developed in-house.

CLAIMS SERVICES
Defense attorney network skilled in psychiatric litigation throughout the country. 31,000+ psychiatric claims managed since 1986.

RISK MANAGEMENT CONSULTATION SERVICE HELPLINE
80,000+ psychiatry-specific risk management issues addressed since 1997, in addition to 1,700+ COVID-19 related calls answered.

REFER A COLLEAGUE
Donations to mental health with each referral! 5,900+ referrals resulting in $51,000+ total donations since 2013. **Visit PRMS.com/refer to learn more!**

More than an insurance policy

800.245.3333 | PRMS.com/Dedicated | TheProgram@prms.com

Insurance coverage provided by Fair American Insurance and Reinsurance Company (FAIRCO), New York, NY (NAIC 35157). FAIRCO is an authorized carrier in California, ID number 3715-7. www.fairco.com.
PRMS, The Psychiatrists' Program and the PRMS Owl are registered Trademarks of Transatlantic Holdings, Inc., a parent company of FAIRCO.

PO BOX 570218
DALLAS, TEXAS 75357-0218

Community Psychiatrist is a publication of the American Association for Community Psychiatry. The views expressed in these articles, columns, and letters are those of the contributing authors and do not necessarily represent the opinions of AACP, its administrative staff, or its editor(s). AACP reserves the right to edit contributions prior to publication.

Please send draft submissions for future newsletter editions to Isabel Norian, MD (belle_note@yahoo.com). Please send inquiries about advertising and announcements to Frances Bell (francesrotonbell@gmail.com).

Subscription is free to members. Others interested in copies of the newsletter may download and print current and past issues through the AACP website: http://www.communitypsychiatry.org.