RELOCATING THE ROOT
Exploring the Possibility of Psychedelic-Assisted Healing for System-Impacted People
A Scoping Literature Review

Authors: Sia Henry, McKenna Leighton, Heath Miller, Joanna Navarro, Raiden Washington, Robert Lugo, Allison Coker, Ismail Ali

Abstract

Psychedelics have an extensive history of sacramental and community use, and have been growing in popularity as promising tools to treat and heal various mental health conditions. Most emerging psychedelic-assisted care (PAC) modalities, however, have not been developed in collaboration with historically oppressed and exploited communities, rendering their effectiveness for these populations unclear. This review explores current research on the prevalence of posttraumatic stress disorder, substance-use disorders, depression, suicidality, adverse childhood experiences, and other mental health concerns among system-impacted people (e.g., currently- and formerly-incarcerated people), particularly those from low-income communities of color. This review proposes the inclusion of system-impacted people in the psychedelic movement requires prioritization of cultural appropriateness, accessibility, and affordability to address their historical exclusion from suitable mental health support and stigma due to criminalization. Furthermore, the authors conclude any efforts relying on PAC for system-impacted people must be developed in relationship with and through the leadership of system-impacted people themselves, especially those from low-income communities of color.

Key Words: system-impacted people, mental health, criminal legal system, PTSD, psychedelic-assisted care

I.Background

As the psychedelic ecosystem makes increasing contact with regulatory contexts, questions have emerged related to how the responsible implementation of psychedelic care modalities can improve mental healthcare. Psychedelics are being studied for a range of potential indications — including posttraumatic stress (PTSD), substance use, depression, and anxiety disorders. Drug development studies have progressed the furthest for MDMA-assisted therapy for the treatment of PTSD, with clinical trial participants primarily representing Veterans, first responders, and survivors of sexual and physical assault and child abuse. (Mitchell et al., 2023)

While all of the aforementioned groups deserve this concerted effort to develop effective treatment models, a significant demographic has been left out of the conversation: those

impacted by the criminal legal system. This group has historically been overlooked when it comes to new treatment development even though they have a disproportionately high prevalence of trauma, substance use disorders, and other complex mental health considerations.

The ongoing "War on Drugs" is a failed attempt to control the illegal drug trade by disproportionately penalizing people of color for possession, use, and distribution of illicit drugs. This has most deeply affected low-income communities of color through the mass separation and alienation of families and communities, extraction of wealth, social stigma, and creation and worsening of mental health issues. (Alexander & West, 2012) The physical and psychological harms caused by punishing people who use and distribute substances, including the impact of violent and oppressive policing and surveillance tactics and inhumane conditions of confinement, are exacerbated by social conditions that criminalize and reinforce poverty and related socioeconomic disparities.

Practically all of American society has been negatively impacted by the existing criminal legal system: from family members of those arrested or incarcerated, to survivors of crime and their loved ones, to those affected by "crimmigration" policies. This review uses the term "system-impacted people" to refer to those *directly* impacted by the enforcement of the system, namely currently and formerly-incarcerated people, those who have been placed on probation or parole including people who are detained, targeted, or otherwise affected by negative contact with law enforcement. At every stage of the criminal legal system, system-impacted people are more likely to be individuals of color, particularly Black, Latino, and indigenous (e.g., Native American). Despite evidence that these groups do not commit more crimes than their white counterparts (Neiwert, 2017), people of color are more likely to be stopped by police; arrested; denied pretrial release, access to a diversion program, or a case dismissal; incarcerated; given

longer sentences (Essex & Hartman, 2022); and denied parole (Hrynkiw & Archibald, 2023). The historical and current legal environment affecting system-impacted people (SIP) — in particular, the targeted oppression, chronic neglect, and "organized abandonment" (Gilmore, 2023) — merits special attention to and prioritization of their unique needs.

The authors intend for this literature review to serve as a critical step in efforts to make more visible the needs of people impacted by the criminal legal system by contextualizing the topic, identifying gaps in the research, and recommending additional areas of focus. Specifically, we explore the mental health needs of system-impacted people, analyzing both pre-existing issues and those that are exacerbated or develop during and following time spent in carceral settings. The authors aim for this review to inform the creation of effective treatment modalities for this population with the additional belief that such modalities must be designed through the meaningful leadership of system-impacted people themselves given their unique lived experiences and wisdom.

II. Mental Health Issues and Needs Among System-Impacted People

The term "mass incarceration" is often used to describe the major increase in the number of people in prisons and jails in the United States that began in the mid-1970s. This figure rose 500% between 1980 and 2014, with the nation now seeing one out of every 31 adults, or an estimated two to three million people behind bars. (Riggs, 2015) Today, the US system of imprisonment is increasingly known as a systematically oppressive institution that perpetuates poverty, is disproportionately applied to people of color, and causes long-lasting, broad impacts on incarcerated individuals, their families, and communities. (Alexander & West, 2012)

In general, direct and even indirect contact with the criminal legal system is highly correlated with adverse childhood experiences, generational trauma, PTSD, substance use issues,

depression, and suicidality. (Burkett, 2017; Dumont et al., 2012; Schnittker et al., 2012) This correlation is most directly evident among people who have been incarcerated, as evidenced, for example, by the observation that "the criminal legal system has become a mental health safety net" for the nation's poorest communities. (Harner et al., 2015) This population is also susceptible to the mental health impacts of traumas experienced during imprisonment. (Liu et al., 2021) In fact, imprisonment trauma may be more strongly associated with mental health conditions compared to childhood trauma and pre-imprisonment trauma. (Liu et al., 2021)

The negative impacts of the criminal legal system, including mass incarceration, are exacerbated by the historical exclusion of low-income people and communities of color from access to healthcare and other resources, further perpetuating intergenerational cycles of neglect, violence, and mental health issues. (Wildeman & Wang, 2017)

A. Mental Health Issues Before and After Contact with the Criminal Legal System

Due in part to the War on Drugs and the elimination of federally-funded public health infrastructure, incarceration has essentially become the nation's response to mental health issues, with prisons and jails being the largest institutions housing the mentally ill in the US. (Bloom, 2010; Dumont et al., 2012) Critically, white people are more likely to receive mental health treatment for illicit substance use and other legal violations than people of color, in part due to racism and inadequate mental health care, thus resulting in the de facto criminalization of mental illness in low-income communities of color. (Dumont et al., 2012) Incarceration and other forms of direct contact with the criminal legal system are both causes and effects of mental illness.

In a review of US health equity, Wildeman and Wang assert the emerging literature on the effects of mass incarceration raises "concerns that excessive incarceration could harm entire communities and thus might partly underlie health disparities both in the USA and between the

USA and other developed countries." (Wildeman & Wang, 2017) The impact of mass incarceration and policy choices that disenfranchise low-income communities of color create a vicious positive feedback loop, whereby exposure to traumatic events, the incarceration of loved ones, and lack of healthcare and employment are both risk factors and effects of imprisonment.

i. The Impact of Racism and Poverty on Mental Health

Since the founding of the United States, racism has had a profound and devastating effect on the distribution of resources and power, impacting the socioeconomic status of racial groups across the spectrum. One can trace the thread of racism through centuries of forced displacement, genocide, and related atrocities committed against peoples indigenous to what is now considered US territory. (Fixico, 2023) This same thread weaves through the economic exploitation of Black people during slavery (Baptist, 2016), indentured servitude, and now low and unpaid prison labor. (ACLU, 2022) Commingled throughout this history are other innumerable examples of the impact of systemic racism on socioeconomic status, such as employment discrimination (Schaeffer, 2023) and the well-documented practice known as "redlining," which involved the denial of financial services such as mortgages and insurance loans to people, especially Black Americans, in specific neighborhoods. (Gross, 2017) Together these factors paint a clear picture of how the deliberate and systematic extraction of human labor and other social and economic resources over centuries created an economy that benefits a majority-white ruling class and prevents people of color from building and maintaining financial stability, never mind wealth.

Low-income communities experience a higher prevalence of poor mental health outcomes due to social factors, including housing insecurity, inconsistent access to financial

resources, environmental obstacles, high rates of crime and violence[1], and inadequate public education. (Hodgkinson et al., 2017) All low-income communities are at increased risk of mental disorders, regardless of race or ethnicity. (Burns, 2015; Ravi et al., 2023) Nonetheless, the mental health of people of color is more likely to be impacted by poverty because they are more likely to have lower incomes and to live in historically oppressed and exploited[2] neighborhoods with fewer resources (Zare et al., 2022), including adequate mental health services.

People of color are also less likely to utilize mental health services. (SAMSHA, 2015) Material barriers to mental health treatment options include lack of financial resources, adequate and consistent health insurance coverage, access to transportation, and time. (Hodgkinson et al., 2017) Given the inflexibility and instability associated with low-wage employment, low-income families struggle to make doctor visits that are often during business or working hours. (Hodgkinson et al., 2017) Low-income people of color experience additional psychological barriers to seeking care, including cultural stigma and, perhaps more importantly, fear and mistrust of the medical system due to interpersonal and historic harms such as institutionalization, misdiagnosis and overmedicalization, family separation, abuse, and the compounded psychological effects of centuries of systemic racism. (Burkett, 2017; Hodgkinson

[1] It is important to name that such high rates of crime and violence are neither unique to communities of color nor an innate characteristic of these populations. Instead, crime within these communities must be considered in light of the impact of structural racism and related socioeconomic disparities. (Hinton & Cook, 2021). Relatedly, the War on Drugs has fueled violence in Black and Brown communities. (Thompson, 2014). With respect to crime rates themselves, low-income communities of color tend to have higher reported rates of crime due to the disproportionately and intentionally higher rates of policing and other forms of state surveillance in these neighborhoods. (Gellman & Adler-Bell, 2017).

[2] Wherever possible, this review uses terms such as "historically oppressed and exploited" as opposed to "marginalized," "vulnerable," "disadvantaged," etc. The authors believe it is important to use terminology that most accurately reflects the history and impact of harmful, targeted, and deliberate systemic efforts on certain populations. The authors recognize that designating certain communities "vulnerable" or "disadvantaged," for instance, erroneously paints these populations as being in constant need of charity or "saving" rather than liberation. Similarly, this review uses people-first language such as "currently-" and "formerly-incarcerated people" in place of labels like "prisoners," "inmates," "ex-cons," or "offenders" and refers to people as "survivors" of harm rather than "victims." This is meant to affirm the ever-changing nature of human existence, recognizing that "[e]ach of us is more than the worst thing we've ever done" (Stevenson, 2015) or have experienced.

et al., 2017) Community-based participatory mental health research and services may be uniquely suited to address material and psychosocial barriers to mental health treatment for low-income communities of color. (Belgrave & Berry, 2016)

ii. Adverse Childhood Experiences

It is well documented that difficult or traumatic childhood experiences are risk factors for mental illness and involvement with the criminal legal system. Both the National Institute of Justice and the Office of Juvenile Justice and Delinquency Prevention have supported many studies investigating this relationship and possible interventions. In a review of these studies, Wyrick and Atkinson write that the profound effects of childhood trauma extend well into adulthood and include psychological, behavioral, social, and even biological changes. "These effects," they claim, "are associated with longer-term consequences, including risk for further victimization, delinquency and adult criminality, substance [use disorders,]. . . poor school performance, depression, and chronic disease." (Wyrick & Atkinson, 2021)

The Adverse Childhood Experiences (ACE) questionnaire has gained traction within scientific, medical, and policy fields as a means for evaluating correlations between difficult (and potentially preventable) childhood experiences and mental and physical health outcomes. (Finkelhor et al., 2013) Given its multi-disciplinary popularity, including adoption by the Centers for Disease Control (CDC) and World Health Organization (WHO), it has been invaluable in advocating for childcare and illuminating the impact of economic and racial discrimination on lifetime disease prevalency, incarceration, and employment outcomes. (NHTTAC, 2024)

Research demonstrates both a correlation and a causal pathway between ACEs and mental illness. ACEs may evoke toxic stress responses that can affect the development and

functionality of neurological, immune, and endocrine systems. (Boullier & Blair, 2018; Merrick et al., 2019) Theoretically, these changes may mediate mental distress and increase the likelihood of additional mental health risk factors, including socioeconomic status, health risk behaviors, educational attainment, and employment. (Merrick et al., 2019)

ACE scores predict mental health outcomes. Adverse childhood experiences, especially those correlated with incarceration, may cause PTSD or increase the likelihood of developing PTSD, even after accounting for lifetime traumatic stress. (Frewen et al., 2019) Likewise, ACEs are correlated with depression, substance use disorders, anxiety, psychosis, personality disorders, and suicide (Sheffler et al., 2020).

Childhood adversity is also strongly correlated with incarceration. (APA, 2024; Merrick et al., 2019; Wyrick & Atkinson, 2021) According to the CDC, about 64% of adults report experiencing at least one ACE, and about 17% report experiencing at least four. (CDC, 2024) In contrast, a shocking 98% of incarcerated people have experienced at least one ACE, and more than 75% report experiencing at least four events. (APA, 2024; Nembhard & Lima, 2022)

Childhood adversity is also correlated with race and ethnicity. People of color have "substantially higher prevalences of four or more types of adverse childhood experiences, compared with whites." (Merrick et al., 2019) For instance, Black youth are almost twice as likely as their white peers to fall into the "High [Socioeconomic Status] Adversity and Paternal Incarceration" class, which is "characterized by above average probabilities of experiencing family economic hardship, parental separation, low maternal education, and paternal incarceration." (Zhang & Monnat, 2022) Importantly, ACE events that are more common among racialized communities may be more significantly correlated with incarceration. For example, children who experience parental incarceration are five times more likely to enter the criminal

legal system themselves. (Dumont et al., 2012) In a review of ACEs, one set of researchers found race and ethnicity were correlated with different patterns of ACE exposure and concluded there is a need for racially-tailored treatment and interventions. (Zhang & Monnat, 2022)

While experiences captured in the ACE measure demonstrate mutually reinforcing associations between childhood adversity, race/ethnicity, mental health, and likelihood of criminal-legal-system contact, the ACE measure may not be optimally designed to capture experiences especially common and impactful among low-income communities and communities of color. (Zhang & Monnat, 2022) The measure does not adequately capture cultural, structural, and systemic forms of oppression, including income inequality, racism, and unhealthy housing conditions (Winninghoff, 2020), which are more common among Black and Latino youth (Zhang & Monnat, 2022).

Moreover, the measure does not reflect the frequency or severity of traumatic events, which engenders limitations on nuance and granularity. For example, the ACE count assumes each event category is equally impactful and is used to measure the cumulative risk of adversity categories based on the assumption of an additive or linear dose effect. Zhang and Monnat write, ”this approach does not account for the important and dynamic interplay among adversities and precludes understanding the heterogeneous impacts of ACEs.” (Zhang & Monnat, 2022) In contrast, they have found “adversities occur in meaningful clusters” by adopting a mixture modeling approach. (Zhang & Monnat, 2022) Given all of this, while research using the ACE measure does support the finding that adverse childhood events are a risk factor for system contact and adult mental health disorders, the impact of childhood adversity among SIP may be even higher than the measure can conceive.

iii. The Criminal Legal System's Impact on Mental Health

Interactions with the criminal legal system may cause new mental health issues or exacerbate symptoms that existed prior to entry. (Wildeman & Wang, 2017) More research is needed to better characterize mental health before and after system contact. Still, preliminary studies indicate that arrest and incarceration have deleterious consequences for mental health, especially among those from and returning to highly oppressive social conditions. (Sugie & Turney, 2017) Whereas some studies have not found evidence of an independent relationship between incarceration and general mental health due to the number of confounding variables, research does indicate incarceration is independently correlated with subsequent mood disorders and, importantly, related disability. (Schnittker et al., 2012) More rigorous research is needed to develop our understanding of the mental health impact of contact with the criminal legal system. Until then, attending to experiential components of incarceration and system contact is invaluable for estimating the mental health impact.

Incarceration is a highly variable experience with many direct and indirect consequences compromising the physical and mental health of incarcerated people, their families, and their communities. (Wildeman & Wang, 2017) Incarceration disconnects and separates families; creates a loss of autonomy; and subjects people to intense surveillance, the ongoing threat of punishment, cruel and unpredictable conditions, and exceptionally high rates of exposure to traumatic events, including experiencing and witnessing violence. (Haney, 2001)

Countless studies have examined the high levels of violence and related traumatic events in prisons and jails (Dholakia, 2023; Hopwood, 2021), while 2018 data from the Bureau of Justice Statistics shows prisons are becoming increasingly dangerous (Wang & Sawyer, 2021). At least 35% of incarcerated men and 24% of incarcerated women have experienced some form

of physical victimization behind bars, while 10% of men and 25% of women have been sexually victimized. (Widra, 2020) Rates of sexual violence have been so concerning that, in 2003, Congress unanimously passed the Prison Rape Elimination Act (PREA), intending to analyze incidences of and protect individuals from prison rape. ("Prison Rape Elimination Act," 2003) Several, however, have written about PREA's inability to engender systemic and lasting change (Martin, 2021), with some specifically highlighting the Act's failure to reduce "the gender-based and sexual violence against incarcerated people that is perpetuated most frequently by correctional staff" (Palacios, 2017).

According to a meta-analysis, potentially traumatic events during incarceration, including victimization and abuse, solitary confinement, and coercion, were significantly positively correlated with PTSD outcomes, whereas both pre-incarceration mental health issues and duration of incarceration did not yield significant correlation, suggesting the frequency of traumatic events and unique conditions of incarceration are more impactful than pre-existing health issues. (Piper & Berle, 2019)

In addition to studies exploring the general psychological impact of the criminal legal system, a body of research has also found involvement in the system may exacerbate existing, if not cause, mental health issues in young people. One study found youth incarcerated for less than one month had higher rates of depression in adulthood than similarly-situated youth who were not incarcerated. (Barnert et al., 2017) Meanwhile, young people who were incarcerated for one year or more were over four times more likely to experience depression and twice as likely to have suicidal thoughts in adulthood compared to those who had not been incarcerated. (Barnert et al., 2017) Among youth involved in the juvenile legal system, "including those who have been referred to court or those who have been adjudicated and placed in a residential facility . . . only

a small percentage . . . in need of services can access treatment", with several studies finding less than 10% of convicted youth in various systems being referred for mental health services. (Development Services Group, 2017) Even incarcerated young people with diagnosed psychological disorders have less than a 25% chance of receiving treatment, with several studies shedding light on race-, gender-, and age-based disparities in which youth are most likely to be referred for treatment. (Development Services Group, 2017) Collectively, studies have found white youth, girls, and younger youth (usually those under 15 years of age) are most likely to be referred for mental health placement. (Development Services Group, 2017)

In addition to causing or exacerbating mental distress, the criminal legal system can also interfere with an individual's access to health care. Once a person is convicted of a crime, and even after they have completed their sentence, they are left to grapple with any combination of the more than 45,000 state and local laws and regulations that limit, if not prohibit, their access to employment, housing, healthcare, voting, education, occupational licensing, and other opportunities. (Kimble & Grawert, 2021) These restrictions impact an individual's ability to find, receive referrals to, or afford treatment. These barriers, widely known as "collateral consequences" of a criminal conviction, include the exclusion of currently incarcerated people from being eligible for Medicaid, causing a gap in insurance coverage upon release. (Widra, 2022) For many, this can be fatal. Subpar care in penal institutions and the post-release healthcare coverage gap "are pivotal factors in the heightened risk of death after release" and other catastrophic clinical outcomes. (Widra, 2022) Various studies have found the risk of death (including from suicide and drug overdose) is particularly high within the first year after release. (Widra, 2022) "Many of these deaths following release are preventable with appropriate medical, mental health, and substance use interventions, which usually require health insurance. But

because people are released from prisons and jails without insurance, they are less likely to receive the necessary interventions upon release." (Widra, 2022)

iv. Psychological Consequences in the Black Community of "Secondary" Contact with the Criminal Legal System

In addition to the harm caused by direct interaction with the criminal legal system, a growing body of research is exploring the impact of witnessing police brutality on the mental health of Black communities. A 2018 study found "police killings of unarmed [B]lack Americans have a meaningful population-level impact on the mental health of [B]lack Americans." (Bor et al., 2018) Specifically, law enforcement officer(s) killing an unarmed African American triggered days of poor mental health for Black people living in that state over the following three months. (Bor et al., 2018) Researchers noted these findings are likely underestimating the cumulative mental health impact of these killings, especially in light of their widespread news and social media coverage. (Bor et al., 2018) The same effect was not found among white respondents, and there was no observable effect in either demographic following police killings of unarmed white Americans or armed Black Americans. (Bor et al., 2018). The researchers emphasize the episodic nature of racialized police brutality to explain the widespread mental health impact of the single event. They posited their "results point to the importance of structural racism as a driver of population health disparities", arguing that "[r]acial disparities in law enforcement and legal treatment have a long history in the USA, and state-sanctioned violence in particular has been used to terrorise, dehumanise, and subjugate black Americans." (Bor et al., 2018) Police killings of unarmed Black people are perceived by many as

“manifestations of structural racism and as implicit signals of the lower value placed on [B]lack lives by law enforcement and legal institutions—and by society at large.” (Bor et al., 2018).

Some have articulated the concept of “accelerated aging” or “biological weathering,” based on evidence that “African Americans are aging biologically more rapidly than whites" as a result of the accumulated stress of experiencing systemic racism, including exposure to the criminal legal system, even if it is indirect or vicarious. (Pazzanese, 2021) More research is needed to better understand this phenomenon and how it may impact long-term mental health, especially among communities most heavily policed and exposed to the carceral system.

B. Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is disproportionately common among SIP. The reported rates of PTSD prevalence for this population are highly variable, indicating a need for more standardized and rigorous research with representative samples. PTSD rates among SIP may be difficult to accurately determine due to lack of treatment and subsequent underdiagnosis (Panchal et al., 2022); cultural, class, and gendered differences in self-disclosure; cultural differences in conceptualizing mental health (Carpenter-Song et al., 2010; Panchal et al., 2022); confounding medical issues (Lewis et al., 2018); and the prioritization of physical health issues among highly marginalized communities.

To partially address these constraints, researchers have often preferred to study proxies for PTSD, including trauma exposure or self-reported symptom severity. Studies have found more than 90% of people who experience incarceration have experienced at least one traumatic event that meets DSM-V diagnostic criteria for PTSD. (Komarovskaya et al., 2011; Pettus-Davis et al., 2019; Wolff et al., 2014) Furthermore, studies frequently report high rates of incarcerated

people who experienced or witnessed physical violence and/or sexual abuse during childhood. (Briere et al., 2016; Komarovskaya et al., 2011; Wildeman & Wang, 2017; Wolff et al., 2014)

One meta-analysis reviewed eligible studies for an estimation of PTSD prevalence among SIP. The study found the prevalence of PTSD among 50 international samples ranged from 0.1% to 27% for incarcerated men and 12% to 38% for incarcerated women. (Baranyi et al., 2018) It is important to note, however, lifetime prevalence of PTSD was found to be higher in the US (Baranyi et al., 2018) than other developmental countries, likely due to differences in rates of incarceration, solitary confinement, economic inequality, systemic racism, healthcare access, and incarceration environment. Smaller studies and studies within high-security prisons report higher prevalence of PTSD (Briere et al., 2016; Harner et al., 2015; Wolff et al., 2014). Variability aside, it is clear SIP have much higher rates of PTSD than the general public.

Research is also divided in determining the impact of incarceration on PTSD. It is challenging to study whether traumatic events experienced during incarceration cause PTSD due to the high prevalence of pre-incarceration PTSD and other mental illnesses. It is likely, however, that prison exacerbates pre-existing PTSD. One meta-analysis found that, although imprisonment trauma was underrepresented in the sample, it was still more strongly correlated with trauma disorders. (Liu et al., 2021) According to a self-report survey of *DSM-V* PTSD symptoms among a sample of formerly-incarcerated people, 72% of recently released participants reported struggling with prison-related PTSD, with only 10.7% having a PTSD diagnosis prior to incarceration. (Jones, 2020) Studies also report high rates of trauma exposure during incarceration. A meta-analysis reports about 90% of incarcerated people experience potentially traumatizing events. As many as 35% of males and 24% of females report directly experiencing physical assault during incarceration (Blitz et al., 2008; Fazel et al., 2017), though additional

studies indicate these numbers may be much higher (Jones, 2020). Another study found, on average, incarcerated people experience potentially traumatizing events every month. (Hochstetler et al., 2004) Despite the variability in the literature, these studies consistently report a positive correlation between trauma exposure during incarceration and the occurrence and severity of posttraumatic stress and depression symptoms.

Other aspects of incarceration may also play a significant role in PTSD outcomes. One meta-analysis found individuals' perceptions of coerciveness and the threatening nature of prisons was associated with posttraumatic cognitions and trauma symptoms upon release. (Piper & Berle, 2019) It should be noted, however, that some methodological flaws, including the low amount of qualifying studies for systematic review and lack of demographic diversity, limit this study's generalizability. (Piper & Berle, 2019)

Even when released, formerly-incarcerated people are more likely to develop PTSD than the general population, including due to the late onset of PTSD following removal from a traumatizing environment. (Jones, 2020) Prison culture is a direct catalyst for constant exposure to PTSD-associated environments, comparable to experiencing military combat, acts of terrorism, sexual assault, and overall abusive and toxic environments. (Jones, 2020) Moreover, the obstacles SIP face upon reentry likely exacerbate PTSD or subject SIP to additional trauma.

It is important to note the limitations of existing diagnostic materials. For example, the *DSM-V* diagnosis of PTSD must be linked to a single or series of events and, therefore, is limited in its ability to measure the compound effects of severe trauma histories marked by diverse or distinct traumatic events. The recent addition of Complex-PTSD (C-PTSD) in the International Classification of Diseases 11th Revision (ICD-11) may support research efforts to investigate PTSD severity with greater granularity. In contrast to PTSD, C-PTSD is "typically associated

with chronic and repeated traumas and includes not only the symptoms of PTSD but also disturbances in self-organization reflected in emotion regulation, self-concept and relational difficulties." (Cloitre, 2022) The ICD-11 description of C-PTSD identifies traumatic events "from which escape is difficult or impossible" which may be of particular consequence for evaluating the severity of incarceration-related trauma due to its coercive nature. (WHO, 2024)

Nonetheless, both the *DSM-V* definition of PTSD and the ICD-11 definition of C-PTSD exclude many types of acute and chronic trauma people of color tend to experience with greater frequency and intensity compared to other groups, including racial trauma and some sources of developmental trauma. (van der Kolk, 2009; Williams et al., 2018) These limitations impact our ability to estimate the severity and nature of posttraumatic stress and the effectiveness of treatment options among SIP communities before, during, and after incarceration.

Finally, people with PTSD often struggle with simultaneous mental health disorders. PTSD is strongly associated with major depression and anxiety disorders, moreso among incarcerated adults than youth. (Facer-Irwin et al., 2019) There is also a "significant association between PTSD and suicidality, with risk estimates slightly higher among [incarcerated men]." (Facer-Irwin et al., 2019) Lastly, incarcerated people with PTSD are significantly more likely to have a comorbid substance use disorder. (Facer-Irwin et al., 2019)

C. Substance Use Disorders

As noted above, the current global drug control mechanism has caused a significant increase in prison and jail populations as a result of drug-related offenses, and these offenses are often interwoven and conflated with issues related to substance use disorders. The criminalization of drugs has resulted in the de facto criminalization of addiction, often addressed

via punishment rather than rehabilitation. According to the National Institute on Drug Abuse, 65% of the prison population has an active substance use disorder (SUD), while an additional 20% did not meet the criteria for SUDs but were under the influence at the time of their crime. (NIDA, 2020) Around 25% of newly incarcerated people have an alcohol use disorder, with an estimated 25% of men meeting the criteria for alcohol use disorder upon arrival. (Fazel et al., 2017) The frequency of drug use disorders is comparable to that of alcohol use disorders, though the prevalence of drug use disorders is higher among incarcerated women. (Fazel et al., 2017)

Despite the high prevalence of SUDs in prisons and jails, there is a clear "treatment gap for SUDs inside prisons." (Fazel et al., 2017) Treatments vary widely across prisons and jails, with only a minority of incarcerated people receiving SUD treatment from a trained clinician. (Wakeman & Rich, 2015) Consequently, incarcerated people lack access to evidence-based treatment (Wakeman & Rich, 2015) despite a high availability of illicit substances in facilities, often smuggled in by staff and visitors (Office of the Inspector General, 2003). Without a comprehensive strategy to address SUDs, incarcerated people will continue to face an increased risk of premature mortality and drug-related recidivism after release. (Fazel et al., 2017)

As mentioned above, a majority of currently-incarcerated people are in the system due to drug use and/or drug-related offenses, behaviors, or activities. When people are released, they are especially vulnerable to SUDs. According to a study on substance use after release from prison, more than 80% of incarcerated people report having used illicit substances in their lifetimes, with 18% having used illicit drugs and 23% having used alcohol five weeks after release. (Chamberlain et al., 2019) Risk factors impacting the likelihood of drug or alcohol use after release from prison include pre-existing substance use disorders, gender, parole status, and time elapsed between release and first medical encounter. (Chamberlain et al., 2019) A history of drug

use disorders was found in 45% of recently released people and associated with post-release substance use, with 24% of those with a history of substance use disorders self-reporting substance use after release. (Chamberlain et al., 2019)

Formerly-incarcerated people frequently return to environments that trigger relapse to drug use and put them at a higher risk of overdose in the immediate post-release period. (Binswanger et al., 2012) During this time, return to drug use most often occurs when people have inadequate access to social, medical, and financial resources to support their re-entry. (Binswanger et al., 2012) It is important, then, to highlight that people convicted of drug-related crimes may be impacted by legal and social restrictions on economic opportunities, federal limits on the provision of public housing and other social safety nets, and legal and social barriers to community participation. (Massoglia & Remster, 2019; Wildeman & Wang, 2017) Those who want to stay away from drugs may face additional social isolation. (Binswanger et al., 2012) Some formerly-incarcerated people intentionally overdose as a way to escape re-entry stressors, and others accidentally overdose due to their decreased tolerance. (Binswanger et al., 2012)

Interestingly, one study cited above found that living with friends or family has the strongest association with post-release substance use. (Chamberlain et al., 2019) Despite this study's finding, however, it is important to note that living with loved ones who pose a positive influence on a person's life can also have the opposite effect by supporting a recently released person in healing from substance use disorders. (Mowen et al., 2019) Structured drug treatment programs, spirituality, religion, and family can prevent relapse and overdose. (Binswanger et al., 2012) Infrequent or unsustained contact with community-based mental health and substance use treatment services, however, does not protect against reincarceration (and "may even be iatrogenic"). (Thomas et al., 2022)

D. Depression and Suicidality

There have been widespread increases in depression in the United States (Goodwin et al., 2022), and the prevalence of major depression has specifically been on the rise in prison populations (Fazel & Seewald, 2012). Incarceration is associated with a 45% increased likelihood of lifetime major depression (Schnittker et al., 2012), though a causal connection is difficult to establish, as the relationship between incarceration and psychiatric disorders are sensitive to childhood background factors and substance use. (Schnittker et al., 2012) Overall, 14% of incarcerated women and 10% of incarcerated men have been diagnosed with major depression (Fazel & Seewald, 2012), with one in seven incarcerated people experiencing depression or psychosis. Psychosis is an important metric because it increases the risk of suicide and self-harm during incarceration. (Fazel & Seewald, 2012)

From 2001 to 2019, suicides increased by 85% in state prisons, 61% in federal prisons, and 13% in local jails. (Carson, 2021) These rates are correlated with increases in major depression, and a majority of the suicides in state and federal prisons occur after an individual has served more than a year. (Carson, 2021) Even though mental health issues are increasing in prison, the prison system does not provide nearly enough support to treat these issues.

E. Mental-Health-Related Reentry Issues Among Formerly-Incarcerated People

Reentry poses many challenges to formerly-incarcerated people, such as accessing adequate healthcare, employment, and housing, and reintegrating into their familial role and community. (Galletta et al., 2021) Successful reentry is especially challenging for formerly-incarcerated people with mental health issues, with this group being significantly more

likely to recidivate and experience homelessness (Galletta et al., 2021), especially when their mental health diagnoses are left untreated (Reingle Gonzalez & Connell, 2014).

The combination of overcrowded jails, long sentences, and unqualified staff has limited incarcerated people's access to meaningful programming during and post-incarceration. (Haney, 2001) Prison staff are also incentivized to keep mental health classifications low to save on healthcare and pharmacotherapy costs. (Reingle Gonzalez & Connell, 2014) A majority of incarcerated people do not receive treatment or treatment continuity for mental health conditions within prison. (Reingle Gonzalez & Connell, 2014) One study found 83% of recently released participants reported not being offered any mental health or general counseling in prison. (Jones, 2020) Meanwhile, carceral systems with established mental health services are often woefully substandard and lack the privacy (including protection from correctional officers) necessary to be effective. ("Coleman v. Brown," 2013) Untreated mental health diagnoses are costly, not only for formerly-incarcerated individuals but also their families and communities (Dumont et al., 2012; Jones, 2020) and for society writ large (Reingle Gonzalez & Connell, 2014).

Generally, regardless of criminal-legal-system involvement, exploited and oppressed communities, particularly those of color, are less likely to receive care or complete treatment for mental health disorders. (Cook et al., 2019; Roberts et al., 2011; Simpson et al., 2007) For those being released after a period of incarceration, unresolved mental health issues interfere with the ability to re-integrate into a social network and employment setting, as well as the ability to resume a familial role (Haney, 2001). As a result, upon release, many formerly-incarcerated people struggle to transition back into society and become susceptible to health risks and reoffending, harming themselves, remaining alienated from their communities, and problematic or illicit substance use. Those with PTSD face severe occupational and social-functional

impairment, high comorbidity with other psychiatric disorders, high medical comorbidity, and reduced quality of life. (Jones, 2020)

Despite substance use disorders being highly prevalent in incarcerated populations, prisons and jails rarely use any evidence-based treatment for addiction. (Wakeman & Rich, 2015) Instead, most use psycho-education, self-help groups, or peer counseling (Wakeman & Rich, 2015). Upon release, there is often no continuity of substance use treatment unless court-ordered.

Returning to a historically oppressed neighborhood after incarceration means facing depleted resources in employment, treatment programs, and housing and difficulties staying out of trouble. (Liu et al., 2021) Formerly-incarcerated people who struggle with substance use disorders may be tempted by the presence of drugs in their environment. (Liu et al., 2021) Additionally, some communities face higher risks of violence, causing some formerly-incarcerated people to avoid leaving their homes (Liu et al., 2021). This contributes to higher vigilance and hostility toward others, triggering an increase in depressive symptoms (Liu et al., 2021) and motivation for the use of illicit substances. Formerly-incarcerated people's concerns over their neighborhood environments predicts their social withdrawal and mental health deterioration. The situation is often a lose-lose one: either they give in to the temptation of social substance use and risk recidivism or isolate themselves and worsen their mental health.

There is also a lack of effective government programs to assist formerly-incarcerated people transitioning back into society and in need of mental health treatment. There is, however, evidence of a small number of community-based programs using effective models to support this population. For instance, Homeboy Industries in Los Angeles, CA, provides free job training and social services to previously incarcerated individuals. The organization has a mental health department providing trauma-informed, individualized clinical services uniquely designed to

meet the needs of their formerly-incarcerated clients. Haney additionally suggests three areas of policy interventions to ease the transition from prison to home: significant changes in the normative structure of prisons, transitional services to prepare for community release, and community-based services to facilitate and maintain re-integration. (Haney, 2001)

F. Critical Perspectives on Diagnosis-Based Frameworks

Diagnostic-based frameworks may be critical tools for ensuring adequate treatment and resource allocation for people struggling with mental distress, including for low-income people of color impacted by the criminal legal system. These frameworks, however, are not developed or employed in a psychodynamically sterile, objective clinic. While this paper is not the appropriate place for an in-depth critique of the *DSM-V Diagnostic Manual* or related frameworks, it is critical to mention some of the ways SIP may be harmed by over-medicalizing symptoms of distress and the therapeutic interventions that rely on such frameworks.

The most digestible criticisms, and the easiest for medical institutions and practitioners to quickly address, are that the *DSM-V* diagnostic criteria and diagnostic tools do not adequately capture racial differences in clinical presentations of symptoms and that the subsequent inadequacy, mixed with physician bias, results in disproportionate misdiagnosis of low-income people of color. The history of schizophrenia and bipolar diagnoses serve as excellent examples of this phenomenon. Many studies since the 1970s have revealed that the racial disparity in the diagnosis of schizophrenia and bipolar disorder is illegitimate. Black patients, especially men, are more likely to be diagnosed with schizophrenia and less likely to receive diagnoses for mood disorders. (Baker & Bell, 1999; Faber et al., 2023) Yet when the same patients are screened with gold-standard diagnostic tools or screened explicitly for depression, rates of schizophrenia and depression do not meaningfully differ between Black and white populations. (Baker & Bell,

1999; Gara et al., 2019) Similarly, several studies have revealed that only about 30% to 40% of patients diagnosed with bipolar disorder actually met clinical criteria (Ghouse et al., 2013; Mitchell, 2012; Ruggero et al., 2010), and bipolar disorder misdiagnosis is most likely to affect people from low-income communities of color with histories of traumatic experiences, major depression, and comorbid substance use disorders (Fusar-Poli et al., 2017; Haeri et al., 2011; Mitchell, 2012).

The history of schizophrenia overdiagnosis among Black patients is a critical case study because the story reveals the intricate ways social issues and discourse affect the implementation of mental health diagnostic frameworks. For example, New York psychiatrists Walter Bromberg and Franck Simon capitalized on the 1968 publication of the DSM-II to publicly advance the idea that the activism characterizing the Black Power movement was both an example and cause of schizophrenia. This idea circulated in medical journals, pharmaceutical advertisements, news coverage, and magazine articles. (Faber et al., 2023; Metzl, 2009) By creating the caricature of the violent, insane Black patient in the US public and medical spheres, these racist tropes set the stage for the misperception, overvaluation, and misdiagnosis of "psychotic" symptoms within Black patient populations, which has contributed to the overdiagnosis of lifetime personality disorders, overprescription of antipsychotics, inappropriate mental health treatment, institutionalization in hospitals and prisons, and the use of medicine as a disciplinary mechanism for non-compliant subjects. (Faber et al., 2023; Metzl, 2009; Weightman et al., 2020)

This history reveals a deeper critique of diagnostic-based frameworks, begging scientific questions about the clinical usefulness and validity of mental health diagnoses and anthropological and legal questions about the role of power and hegemony within the practice of medicine. A relevant critique is that contemporary diagnostic-based frameworks engage in what

has been described as the "privatization of stress" (Fisher, 2009), whereby natural, and sometimes even healthy, responses to political and environmental factors, such as poverty, war, climate collapse, targeted policing, and systemic racism, are conceived as pathological symptoms of a disorder with genetic or neurological etiologies (Doyen, 2021). This is often done with insufficient scientific evidence to support the purported etiology. As a result, individuals end up pathologized in ways that significantly affect their economic and social opportunities and self-concept, rendering them vulnerable to ineffective voluntary and involuntary treatment, while the underlying systemic cause of the distress is obscured. More broadly, some have argued contemporary psychoanalysis and psychotherapy have traditionally played a role in seeking to produce compliant subjects "well-adjusted" to, if not accepting of, their own oppression.[3]

For these reasons, the development of new treatment options for low-income people of color impacted by the carceral system must necessarily involve the leadership, advocacy, and voluntary participation of those impacted by the same systemic issues. Community-based participatory research and advocacy may support the development of treatment models that effectively reduce individual and community distress while simultaneously addressing systemic issues.

II. PSYCHEDELIC INTERVENTIONS

A. Status of Psychedelic Interventions to Reduce Post-Traumatic Stress Disorder (PTSD), Substance Use Disorder (SUD), Major Depressive Disorder (MDD), Treatment Resistant Depression (TRD), and Suicidality

A growing body of research has found psychedelics to have promising potential in addressing debilitating mental health issues including PTSD, MDD, TRD, and SUDs. In March

[3] This is similar to ideas around "rehabilitation" of people convicted of crimes. "Oftentimes, when people talk about 'rehabilitation' what they are really seeking is assimilation and compliance." (Henry, 2021)

2019, for instance, the FDA approved the use of esketamine for the treatment of treatment-resistant depression (Gastaldon et al., 2019). Meanwhile, the clinical investigation of many psychedelics are advancing for a range of different clinical indications (Kurtz et al., 2022; Rucker et al., 2018). Resilient Pharmaceuticals (formerly known as Lykos Therapeutics) has reported impressive safety and efficacy data in two Phase III clinical trials to support the approval of MDMA-assisted therapy for PTSD (Lykos, 2024). Johns Hopkins Medicine has also completed waitlist-controlled pilot studies demonstrating the initial efficacy of psilocybin in treating major depressive disorder (Johns Hopkins, 2022). The FDA has granted breakthrough therapy designation for MDMA for the treatment of PTSD and for psilocybin for the treatment of both MDD and TRD (Heal et al., 2023). Psilocybin-assisted therapy has also been demonstrated to reduce heavy drinking by 83% among individuals with alcohol addictions (Bogenschutz et al., 2022). As of March 2026, Phase 3 clinical trials are underway for psilocybin, LSD, and ketamine based treatments for Major Depressive Disorder (MDD) (National Institutes of Health, 2025, 2026b, 2026c), Treatment Resistant Depression (TRD) (Goodwin et al., 2025), Generalized Anxiety Disorder (GAD) (National Institutes of Health, 2026a), Severe Alcohol Use Disorder (AUD) (Morgan, 2026), and Suicidal Depression (National Institutes of Health, 2024; Walters, 2025). There are 58 active Phase 1, 2, and 3 clinical trials investigating psychedelics for a range of clinical diagnoses and dozens more studies in the Preclinical and Discovery stages (Haichin, 2026). These initial findings suggest psychedelics could be a promising tool to support system-impacted people in overcoming SUD, PTSD, MDD, TRD, and other debilitating mental health issues (but see Section III(C) for a discussion on limitations for SIP).

As with any medication, psychedelics are not without risks. Common side effects include increased heart rate, nausea, muscle tension, headaches, anxiousness, difficulty sleeping, body

temperature dysregulation, and water retention (Holze et al., 2020; Johnson et al., 2008; MacCallum et al., 2022). These effects typically pass within hours and do not require medical intervention. Symptoms can be managed with prescription or over-the-counter medications (e.g. Zofran for the treatment of nausea). Rare side effects may include seizures or serotonin syndrome, typically as a result of an existing seizure disorder or use of psychedelics in conjunction with other serotonergic medications such as antidepressants (SSRIs, SNRIs, MAOIs, etc) or amphetamines (Johnson et al., 2008; MacCallum et al., 2022). Careful screening for medical contraindications including cardiac conditions, hypertension, heart disease, symptomatic liver disease, pregnancy, and nursing is important for safe and effective treatment (Johnson et al., 2008; MacCallum et al., 2022; Rucker et al., 2018). For some treatment protocols, patients may be required to pause use of antidepressants (SSRIs, SNRIs, MAOIs, etc), amphetamines, or benzodiazepines to avoid potential medication interactions (Johnson et al., 2008; MacCallum et al., 2022; Rucker et al., 2018).

Psychedelics may also carry a risk of adverse psychological reactions, particularly for vulnerable individuals. Case reports suggest that Serious Adverse Events (SAEs) such as suicidal ideation or psychosis and Nonserious Adverse Events (NSAEs) such as transient anxiety, headaches, or fatigue are a risk. Many clinical trials screen for potential contraindications including Bipolar-I, schizophrenia, severe personality disorders, or a history of severe mania (Holze et al., 2020; Johnson et al., 2008; National Institutes of Health, 2024b). That said, such adverse events are rare in clinical trials and controlled settings. According to a 2024 metanalysis of 3504 participants from 114 studies, SAEs were reported for no healthy participants and approximately 4% of participants with preexisting neuropsychiatric disorders (Hinkle et al.,

2024). More research is needed to establish the safety and efficacy of psychedelic medicines for select vulnerable populations.

B. History of Psychedelic Interventions to Reduce Recidivism

Recidivism, or the rate at which previously convicted people re-offend, is a common metric of success both within the criminal legal system and among community-based organizations operating diversion, re-entry, and other related programs.[4] Recidivism data is also commonly used as a convenient but inaccurate proxy for the mental and behavioral health of formerly-incarcerated people. This data, however, is misleading and fails to take into account the ongoing socioeconomic disparities and racism that often contribute to an individual engaging in additional criminal activity (Rosenfeld & Grigg, 2022). Particularly concerning healing processes, other metrics such as an individual's self-reported sense of improved wellness, stability, happiness, and connection to their loved ones and community may be better goals compared to the decreased likelihood a person will commit a future crime. That being said, some studies have attempted to use psychedelics to reduce recidivism rates.

The most famous study on how psychedelics might reduce recidivism was Timothy Leary's Concord Prison Experiment (CPE) from the early 1960s (Doblin, 1998; Neitzke-Spruill, 2022). The CPE administered psilocybin-assisted therapy to soon-to-be-released, incarcerated people to measure the effects on recidivism. The study both failed to reduce recidivism and revealed the limitations of its design and underlying assumptions (Doblin, 1998; Neitzke-Spruill, 2022). Rick Doblin, founder of the Multidisciplinary Association for Psychedelic Studies (MAPS), wrote an article in 1998 describing the study and its failures (Doblin, 1998). Doblin's analysis is now over 25 years old and mostly helpful for an introductory analysis of Leary's

[4] Nationally, about 75% of people "released from state prisons are rearrested within five years of their release and 55[%] are incarcerated again". (Goldstein, 2014)

problematic study. Still, it does offer some hints for ways to improve this thread of research. One major takeaway from the CPE is that psychedelics are not magical tools that create wisdom and lasting changes after a couple of uses (Doblin, 1998). Instead, effective integration and sustained hard work are typically necessary after psychedelic experiences to solidify healing and behavioral changes (Doblin, 1998). Doblin suggests that whether recidivism declines over the long term is an empirical question that should be examined through new experimental research (Doblin, 1998).

The CPE is still relevant today, in part as a lesson on the limitations of using recidivism as a measure of the success of psychedelic-assisted therapy (PAT) for currently-incarcerated people. More recently, Nietzke-Spruill studied the journals of incarcerated people who participated in Leary's CPE, finding self-reported changes in emotion, sense perception, interactions with other participants, and self knowledge (Neitzke-Spruill, 2022). Confirming the common sense of many, Nietzke-Spruill found that prison's harmful environment constrains the efficacy of PAT as a tool to reduce recidivism. The self-reported changes could not last because, among other factors, the prison's social environment hinders integration, an important step after a psychedelic experience that can support lasting change (Neitzke-Spruill, 2022). Further, the institutional structure of prisons strips incarcerated people's freedom and autonomy to enact meaningful change in their lives (Neitzke-Spruill, 2022). Unlike earlier analyses of the CPE, this study argues the efficacy of PAT as a tool to reduce recidivism is likely limited due to the difficulty of integrating change while in the harmful prison environment.

The material conditions of post-carceral life additionally constrain the efficacy of mental health interventions. Upon release, formerly-incarcerated people often do not have housing, employment, family support, and medical insurance, and may be impacted by legal and social

restrictions on economic opportunities, federal limits on the provision of public housing and other social safety nets, and legal and social barriers to community participation (Massoglia & Remster, 2019; Wildeman & Wang, 2017). Therefore, we must anticipate that the benefits of PAT will be limited without simultaneous efforts to address the social and structural barriers to re-entry (Neitzke-Spruill, 2022). There may also be increased risks of PAT during incarceration or post-incarceration in historically oppressed, exploited, and over-policed communities due to the likelihood of people encountering re-traumatizing events during their treatment. These increased risks demand greater community involvement in the design of a psychedelic-assisted care modality as well as wrap-around support and collaboration with other service providers.

C. Relationship Between Reentry Needs and the Effectiveness of Psychedelic Assisted Care (PAC) Modalities for SIP

As demonstrated above, several studies have found psychedelic-assisted healing modalities to be effective at treating a host of mental-health-related issues, from PTSD to depression and SUDs. It is important, however, to take a cautious and holistic approach when considering how these studies apply to people from historically oppressed and exploited communities, especially those who have been directly impacted by the criminal legal system. As mentioned, system-impacted people have disproportionately high rates of some of these same aforementioned mental health issues while suffering disproportionately low access to competent care.

While PAC modalities may be effective for addressing acute or immediate concerns, the host of reentry-related obstacles suggest PAC approaches alone may be insufficient for realizing sustained healing and well-being for people returning to under-resourced communities following

periods of incarceration. Instead, a psychedelic-assisted healing approach for this population would likely need to be coupled with additional wrap-around support to meet ongoing needs, including access to employment, safe housing, healthy food, culturally appropriate and trauma-informed medical and mental health care[5], and environments that foster a sense of social connection and belonging (Moore et al., 2020). Without these added areas of support and broader systemic change, PAC is likely to be insufficient in disrupting cycles of harm and trauma.

D. Limitations of the Current Clinical Evidence

While the emerging literature on psychedelic-assisted care demonstrates promising results for a range of mental health conditions, it is important to acknowledge the current evidence base remains limited in several ways. For instance, much of the clinical research to date has been conducted with relatively small sample sizes, which can limit statistical significance and the generalizability of findings (Kurtz et al., 2022; Rucker et al., 2018). Furthermore, many studies have relied on highly selective inclusion criteria, often excluding individuals with significant psychiatric comorbidities, active substance use disorders, or unstable socioeconomic conditions (Johnson et al., 2008; Kurtz et al., 2022; MacCallum et al., 2022; Rucker et al., 2018). While these exclusions are designed to reduce risk in clinical trials, they may limit the applicability of findings to more complex, real-world populations.

These limitations are particularly relevant when considering the potential application of PAT for SIP. Individuals who have experienced incarceration or other forms of criminal legal system involvement frequently present with comorbid mental health conditions (e.g.,

[5] For instance, one study found expanded Medicaid insurance coverage "reduced police arrests, particularly drug-related arrests. Combined with research showing the harmful health consequences of chronic policing in disadvantaged communities, greater insurance coverage creates new avenues for individuals to seek care, receive treatment, and avoid criminalization." (Simes & Jahn, 2022). This highlights the importance of different fields of focus working across silos to support social development and personal healing, especially for people from heavily-policed communities.

trauma-related disorders, substance use disorders, depression, etc.) (Coulter et al., 2025; Facer-Irwin et al., 2019; Canada et al., 2022). They may also experience ongoing social stressors such as housing insecurity, poverty, violence, and structural discrimination (Dumont et al., 2013; Trotter et al., 2018). Because many clinical trials of psychedelic-assisted therapies have excluded participants with complex comorbidities and/or socioeconomic instability (Johnson et al., 2008; Rucker et al., 2018), it remains unclear how findings from existing studies would translate to populations facing these compounded challenges.

Relatedly, the existing research on psychedelics is heterogeneous in study design, therapeutic protocols, and outcome measures (Kratina et al., 2026; Kurtz et al., 2022; Wen et al., 2024). Variations in dosing, therapeutic frameworks, integration practices, and clinical settings make direct comparisons across studies difficult and complicate efforts to draw definitive conclusions about effectiveness across different populations.

Perhaps most importantly, there is currently little to no direct empirical research from the last several decades examining psychedelic-assisted care approaches specifically among SIP. As a result, any discussion of the potential relevance of psychedelic-assisted care for this population necessarily relies on extrapolation from studies conducted with different participant groups.

For these reasons, the present review does not interpret the current clinical evidence as definitive. Rather, the authors consider the research exploratory, providing early indications of therapeutic potential while underscoring the need for additional research. Future studies should prioritize more inclusive participant recruitment; community-engaged research design; and careful evaluation of safety, efficacy, and ethical considerations in populations directly impacted by the criminal legal system.

E. Legal Considerations

i. Post-release State Surveillance

Understanding how to ethically apply PAC modalities for SIP requires tracking someone through the entire arc of the criminal legal system. Upon release from a penal institution, many people are required to continue their sentence under supervised release, also known as "parole." Although federal parole has been abolished, many individuals sentenced prior to 1987 remain under supervised release (U.S. Sentencing Commission, 2012; CDCR, 2024). The US Parole Commission is the federal parole board that has jurisdiction over federally-incarcerated people confined before 1987[6] with grandfathered parole status and decides whether to approve parole and what conditions must be satisfied for release (CDCR, 2024). Outside of this exception, most individuals on parole are under such supervision from state facilities and are being supervised by their state's parole board. States have considerable discretion on how much authority their parole boards have and what they may require.

While not everyone gets parole, most people are supervised to some extent post incarceration. For example in California Penal Code section 3451 states that "recently released individuals after serving a felony conviction shall be subjected to postrelease community supervision" (CDCR, 2024).

Regardless of the type of community supervision an individual may be under, there are often a host of technical and procedural rules that, if violated, threaten their return to prison or jail. The length of such supervision varies widely. In California, for instance, Postrelease Community Supervision (PRCS) can last from six months to three years (CDCR, 2024), whereas federal supervised release lasts between one to five years (l8 U.S.C. § 3583). During this time, the use of substances that are legal according to state law but illegal under federal law can

[6] The Sentencing Reform Act of 1984 eliminated parole for federal crimes committed after November 1, 1987.

constitute a violation of one's parole. Parole, PRCS, and other forms of supervised or surveilled release require particular consideration in the context of PAC for SIP because they often include specific restrictions on illicit drug use.

ii. Drug-Related Restrictions and Requirements

Random drug testing is a common condition for federal and state parole, especially for people who committed drug-related offenses or have a history of substance use. Under federal law, the US Parole Commission is permitted to mandate certain conditions of release, including requiring parolees to undergo drug treatment programs (28 Code of Federal Regulations section 2.40). Under 2.40(c), if participation in drug treatment is required, the person must submit to a drug test within 15 days of their release and to at least two other drug tests, as determined by the parole officer. Under 2.40(f), if the person fails any drug test or is found to be in possession of any controlled substance, their release must be revoked and they will be re-incarcerated[7].

Supervised release may contain similar drug restrictions as parole and contribute to recidivism. In California, for instance, drug-related restrictions are common for people on parole (California Penal Code Section 3063.1), with some being subject to urine tests (California Code of Regulations, tit 15, section 3620(a)).

The high cost of potential return to incarceration is a concern that may prevent people on parole or other formerly-incarcerated people from participating in PAC.

[7] The likelihood of failing a drug test depends on the substance ingested and the type of test used. MDMA, for instance, which is one substance used in some psychedelic-assisted therapy modalities, can be detected in a person's system up to two days after consumption via a blood or saliva test, up to three days using a urine test, and up to three months if testing one's hair follicles. (Priory, 2024) While at the time of this writing no state has legalized MDMA and it remains federally controlled, it remains to be seen how future potential medical or other legal access - and subsequent changes in criminal law, if any - will impact whether or not it continues to be screened in a drug test. Notably, the federal government recently announced it is considering removing MDMA from Health and Human Services drug screening panels. (SAMSHA, 2024)

iii. Cannabis and Psychedelics

The fast-changing patchwork of cannabis laws across the nation has made it challenging to track their impact on people on parole or under state surveillance. While at the time of this writing, the federal government is in the process of considering rescheduling cannabis from Schedule I to a less restrictive schedule, cannabis remains federally illegal but legal to different degrees in many states. This poses concerns about enforcement that implicates interrelated state and federal law. While complicated, these questions provide a map to understanding how changes in psychedelic law and policy might unfold.

In the many states where cannabis is legal for medical or adult use under state law, cannabis use and accessibility varies depending on the state and local regulatory policies applicable to a given jurisdiction. In such jurisdictions, use by a person on parole or under state surveillance may still violate parole and could lead to parole revocation. In addition, some counties may still ban people on probation from cannabis use despite statewide legalization (Hager, 2020). In California, medical or adult use of cannabis by individuals on parole is permissible under Cal Health & Safety Code section 11362.795(b)(1), which states "any person to be released on parole [...] and who is eligible to use medicinal cannabis may request he/she be allowed to use medicinal cannabis during the period he/she is released on parole."

Protections implemented into law reduce the risk but may not eliminate it. In fact, many parole authorities do not approve of medicinal or recreational cannabis use and still drug test for it, despite explicit laws permitting use on parole or supervision (Hager, 2020). tate legalization does not always protect people on parole or under state surveillance, such that their use or possession of a substance — even if it has become legal at the state level — risks

reincarceration.[8] This may change if the federal government places cannabis in a schedule other than Schedule I.

Similar legal restrictions and concerns will likely apply to psychedelic use by SIP. Again, overlapping and sometimes contradictory systems of regulation and control create multiple potential contexts for or restrictions around psychedelic use. If a substance is legal in one's state but federally illegal, the potential for conflict and lack of clarity remains for those under community supervision. Even if the agency controlling the supervision does not enforce federal prohibition in practice, an individual using a psychedelic could potentially be open to criminal charges brought by the federal government. In that case, the assigned federal prosecutor may enhance such charges due to the defendant having a prior record. Even in jurisdictions where psychedelics have been decriminalized (as opposed to legalized), these significant potential risks remain if law enforcement agencies choose to engage in discretionary enforcement.

For these reasons, whether on parole or other kinds of supervised release, drug restrictions pose a particular risk for recidivism and, in practice, may exclude formerly-incarcerated people from participating in state-legal psychedelic-assisted services. As long as psychedelics are federally illegal,[9] their use may lead to a parole violation and possibly revocation, making confidentiality and data privacy paramount to ensuring the rigorous protection of individuals' identities and criminal histories.

Potential prosecution is not the only risk to manage. Even in cases of medical use, workplace drug testing can make employment more challenging to acquire or retain for cannabis

[8] Even in states where cannabis is legal, and even if its use is not punished under supervised release programs, its criminalization has lingering effects. Over 40,000 people are still incarcerated for cannabis-related crimes in the United States. (Last Prisoner Project, 2024) When released, they will still face the collateral consequences of their conviction. Having a criminal record, for instance, poses a large barrier to reentry as it limits employment and housing opportunities.

[9] The Federal Drug Administration has granted both MDMA-assisted therapy and psilocybin-assisted therapy "breakthrough therapy" status and may be available for restricted and regulated legal prescription use by 2025.

users (Okechukwu et al, 2019). The use of psychedelics could put people in a similar situation since, like cannabis, the federal illegality of the substances precludes employment protections, regardless of the intention of the use. The same problem may show up with the provision of any social services that require drug testing as part of receiving benefits.

The precedent set by medical marijuana suggests that without some form of federal authorization, individuals on supervised release may be opening themselves up to potential violations of their supervision requirements or other criminal liability by accessing treatment or care, even in a regulated research or state-legal setting.

F. Ethical Considerations

i. Consent and Coercion Under State Care or Surveillance

Many currently- and formerly-incarcerated people undergo a process of institutionalization, making them susceptible to coercion, which is especially harmful to people already in an involuntary and compromised position (Haney, 2003). Conducting clinical research on people under government supervision presents important ethical considerations, requirements, and limitations.

Currently, biomedical research conducted or supported by the Department of Health and Human Services on incarcerated people cannot present "more than [a] minimal risk and no more than [an] inconvenience to [incarcerated people]" and must fall within one of four specific areas of research (45 CFR §46.306). Those areas are: (1) the "possible causes, effects, and processes of incarceration, and of criminal behavior", (2) "prisons as institutional structures or of prisoners as incarcerated persons", (3) conditions of confinement, and (4) practices that "have the intent and reasonable probability of improving the health or well-being of the subject" (45 CFR §46.306).

While individuals on parole or probation are not subject to the same requirements, similar ethical considerations apply.

Psychedelics induce a uniquely vulnerable state both during and after treatment sessions. As such, the use of PAC modalities with currently- or formerly-incarcerated people demands additional restrictions, regulations, and considerations to avoid enhancing the coercion inherent in imprisonment and state supervision. Risks include abuse of power dynamics and other issues between providers and patients, challenges with truly informed consent, conflicts of interest, and providers practicing outside their scope of competency (Anderson et al, 2020).

In addition to enhanced vulnerability, PAC may cause profound and unexpected emotional or behavioral effects, including personality changes that neither the provider, therapist, facilitator, nor client can predict.. Safe and responsible clinical administration and strict ethical and practice standards are required to ensure informed consent and protect against coercion of those under state care and surveillance (Anderson et al, 2020). Given these considerations, experts across the field have concluded that PAC requires elevated training standards, quality assurance, rigorous peer review, and supervision to prepare psychedelic professionals to navigate ethical challenges safely. The stakes are even higher when considering these additional sensitivities as applied to SIP. Additional training on topics such as implicit and explicit bias may be required for providers working with this population.

With regard to issues pertaining to consent, researchers recommend consultation with healthcare providers experienced in working with low-income, formerly-incarcerated communities of color (Anderson et al, 2020). There is also support in the literature for service providers to deliver relevant psychoeducation for related treatment populations. In general, providing psychoeducation about mental health interventions can improve treatment

participation among low-income communities of color (Al-Mateen et al, 2016) by improving diagnostic accuracy, addressing mental health stigma, familiarizing patients with treatment paradigms, improving consent, and building rapport between patient and clinician (Williams et al., 2019). The value of psychoeducation may be emphasized for PAC interventions due to stigma concerning drug use and fear of repercussions (Hutchison, 2020; Burkett, 2017; Leighton & Harrison, 2020). The safe and effective participation of communities of color in PAC modalities may also benefit from community-involved political advocacy and movement building for regulatory reform and decriminalization (Hutchison, 2020).

The authors therefore align with recommendations to create a complex stakeholder engagement process to assure community support and encourage the development of and adherence to best practice guidelines in order to mitigate the risks involved in the treatment of system-impacted populations. (Belouin et al., 2022) Belouin et al. recommend an interagency federal task force and a public-private partnership to collaborate across the various interests of all stakeholders to ensure equitable access to accountable, safe, and ethical uses of psychedelic medicine (Belouin et al., 2022). It is important for different stakeholders (including spiritual, religious, therapeutic, and Indigenous practitioners, etc.) to build trust and work with each other to ensure these aims (Belouin et al,, 2022). Comprehensive consent requirements, strict ethical and practice standards, stakeholder relationships, and accountability would mitigate risks and ensure that enthusiasm for this emerging treatment paradigm does not overstep its benefit by coercing or mandating any individual into receiving PAC.

ii. Risks Related to Court-ordered Treatment Plans

Given the high rates of diagnosed and undiagnosed mental health disorders among SIP, one potential negative downstream effect is the possibility of court-mandated PAC. Regardless of treatment paradigm, legal coercion, especially concerning the therapeutic relationship, may negatively affect treatment outcomes (Hachtel et al., 2019; Klag et al., 2005). Perceived coercion in treatment is linked to an impaired therapeutic process and worse outcomes as compared to voluntary treatment (Hatchel et al., 2019). This suggests that legal coercion undermines the quality and efficacy of mental health interventions.

Courts have the authority to mandate treatment plans to reduce lengths of sentences both during incarceration and upon release. For federal crimes, for instance, U.S.C. section 3563(b)(9) states "the Court may provide the defendant undergo available medical, psychiatric, or psychological treatment, including for drug or alcohol dependency, as specified by the court, and remain in a specified institution if required for that purpose" (DPSPPSO, 2024). State courts have similar authority. Many states are exploring ways to increase the use of involuntary hospitalizations in response to a growing nationwide mental health crisis (Sy & Jackson, 2023). In April 2022, for example, the state of New York amended previous legislation that allowed the legal coercion of outpatient treatment for anyone deemed dangerous to include anyone who might be accused of self-neglect. (Geringer-Sameth, 2022)

It is clear the potential benefits of PAC modalities could be significantly mitigated if utilized in a coercive environment. Any PAC approaches, especially those used with system-impacted populations, should be offered on a voluntary basis and only after providing a sufficient amount of accessible information about the process to ensure the individual can make an informed decision regarding their participation. Ensuring the creation of a stakeholder

engagement process, as described above, may better protect this population from the specter of legally-mandated PAC.

III. CONCLUSION

A. Gaps in Knowledge and Positive Trends

Despite well-documented evidence that people of color have increased rates of trauma and incarceration and face different types of trauma than their white counterparts, treatment of race- and incarceration-based trauma, and with psychedelics specifically, continues to be under-researched. As discussed, clinical therapeutic approaches developed primarily by and for affluent white people may be less effective for communities that have traditionally been excluded from scientific practice and investigation. While the growing psychedelic medicine movement has historically excluded people of color (Michaels et al., 2018), researchers are increasingly aware that including people of color in psychedelic research is both the right thing to do and clinically essential, as their exclusion may limit the generalizability of research findings.

B. Recommendations for Further Research

In conducting this scoping review, the authors identified a number of areas presenting opportunities for additional research. For example, further research might deepen existing understanding about the impact of childhood adversity on mental health by focusing on adversities that are not well captured by the ACE measure. Additional studies could fill the gaps in our understanding of how incarceration affects physical and mental health over the long term, including that of family members. Looking into these topics independent of confounding variables like prior trauma and preexisting mental health issues and risk-factors could provide more precise information to inform future treatment options. Similarly, we recommend people of color should not only be included in but also actively lead psychedelic research, as their

exclusion may limit the generalizability of research findings and frustrate well-intentioned attempts to develop effective, culturally-appropriate approaches.

With respect to psychedelics, we recommend research that identifies and tracks foundational elements and evaluates the knowledge about, interest in, and perceived need for psychedelic-assisted care modalities among SIP. Additional legal research is also needed to draw clearer conclusions about how access to psychedelics in a clinical trial or pilot program, or in a state that has decriminalized or implemented a regulated use program, would practically impact individuals on supervised release. In addition, more research should be done to flesh out ways to reduce the risk of the ethical considerations described in this article, in particular those related to consent, coercion, and conflicts of interests and incentives.

C. Importance of Collaboration with and Leadership of SIP

Formerly-incarcerated abolitionist, author, and scholar Emile Suotonye DeWeaver has argued the project of colonialism relied on socially engineering norms to fabricate white-supremist structures that have formed the basis of our contemporary society. (Deweaver, 2025) No institution is exempt, and our mental health and medical systems have not escaped having racism baked into their core. Given this, it is not enough to simply concede the realities of history and offer empty platitudes. One can not explore the impacts of trauma and the criminal legal system without acknowledging that we as a society find ourselves grappling with the consequences of mass incarceration and related socioeconomic harms as a result of drug policies, racism, and capitalism. It is imperative, then, that we not rely on those same tools and ideologies of white supremacy to attempt to solve problems those very tools created.

As the field of mental health care adapts, it must act to confront and reverse the impacts of its sordid history, including its exploitation and exclusion of oppressed populations. This

literature review leads the authors to conclude that efforts relying on PAC to forge pathways towards healing and wellness for SIP must be developed in deep relationship with, and through the meaningful leadership of, SIP themselves, especially those from low-income communities of color that have been most disproportionately affected.

Some racial and social justice scholars have recognized how the myth of white supremacy has shaped our individual thought patterns, thereby limiting our creative faculty. How can we imagine transformative, inclusive approaches to healing when we ourselves have not experienced them? Modern scientific research shows how psychedelics have the potential to reorganize brains to take on new mental properties, giving us the ability to expand our beliefs about what is possible. Therefore, in addition to materially resourcing the leadership of SIP in exploring healing modalities for their communities, there may be a role for psychedelics to not only assist with that healing but also the process by which people conceive those modalities.

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