APA Resource Document

RESOURCE DOCUMENT ON "WHY SHOULD MORE PSYCHIATRISTS PARTICIPATE IN THE TREATMENT OF PATIENTS IN JAILS AND PRISONS?"

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Introduction

People with serious mental illness are substantially overrepresented in the criminal justice system. (Steadman, et al. 2009; Fazel et al. 2016) This results in a higher prevalence of mentally ill patients in correctional facilities than in the community and the high proportion of justice-involved patients in county and state mental health systems. State hospitals that remain after decades of deinstitutionalization have seen their beds fill with large proportions of criminal court commitments while civil commitments have diminished (Fuller et al. 2016). Public sector community mental health programs typically have sizable populations under an order for care and treatment through probation and parole conditions or conditional release from a hospital after an insanity acquittal (Fuller et al. 2016).

Stigma exists at the criminal justice-behavioral health interface and impacts both sides. Criminal justice professionals may avoid interacting with people with mental illness due to apprehension and a lack of familiarity with effective methods of engagement. In parallel, some members of the psychiatric community are hesitant to work with individuals with criminal justice involvement due to fear and a perception that little can change the underlying factors that contribute to criminal behavior. Mental health professionals may also be wary of working with people perceived as "criminals." Many mental health systems lack clinicians with specialized training to address the dysfunctional and maladaptive behaviors observed in and learned by some justice-involved patients. These behaviors need to be addressed in order to assist such patients in making progress with their mental health conditions, in maintaining public safety, and leading successful lives in the community (Group for the Advancement of Psychiatry Committee on Psychiatry and the Community, 2016).

There is encouraging news for the hesitant psychiatrist who is interested in this important public health endeavor. Promising interventions have been shown to directly reduce criminal behavior, recidivism, and the exacerbation of psychiatric symptoms while incarcerated. In partnership, psychiatrists and their criminal justice colleagues can slow the revolving door for the mentally ill passing in and out of criminal justice settings and create a more integrated system of public mental health care delivery. This document addresses the core question of, "Why is the treatment of justice-involved patients a critical mission for psychiatrists?

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1) Jails, prisons, juvenile facilities, and forensic hospitals have many of the patients most in need of your help.

It has been estimated that there are now more than ten times as many individuals with serious mental illness behind bars in the U.S. as there are patients in state mental hospitals (Torrey et al. 2014). In a vigorous diagnostic assessment of jail inmates in 2009, the rate for serious mental illness was 14.5% for men and 31% for women (Steadman et al 2009). Approximately 65% of youths in the juvenile justice system have diagnosable psychiatric or substance use disorders (Fazel et al 2008; Teplin 2002; Shufelt and Cocozza 2006). Prevalence rates of psychotic disorders in juvenile detention are about ten times that of the adolescent population in the community (Fazel, Doll and Langstrom 2008). Suicide is the leading cause of death in jails and accounts for about a third of jail deaths. At a rate of 46 per 100,000 in 2013 (Noonan 2015), this is about double that of the male adult population in the community.

2) While the contexts vary, the clinical needs are everywhere.

Correctional facilities have a constitutional duty to provide necessary mental health services to those individuals in their care and custody (Jones 2015). These facilities include jails, prisons, juvenile correctional facilities, and forensic hospitals. Providers in these settings face a number of challenges, including limited privacy, underfunded health systems, dual loyalty challenges related to potential conflicts between health and security, exposure to violence, racial tension, and a high prevalence of patients who have been exposed to developmental trauma. Therefore, skilled correctional psychiatrists must be able to maintain respect for security and multi-disciplinary staff while always striving for the best interests of the patient.

Jails typically house individuals awaiting adjudication or those sentenced to less than one year, while prisons typically house individuals with felony convictions and longer sentences. The rapid turnover of individuals in jails necessitates a substantial number of time-consuming and intensive initial assessments while providers in prison settings are more likely to engage in long-term treatment with individuals with serious and persistent mental illness. The American Psychiatric Association's Workgroup on Psychiatric Services in Correctional Facilities recommends one prescriber for every 75-100 patients with serious mental illness on psychotropic agents who are in jail and one prescriber for every 150 patients with similar clinical conditions in prison (American Psychiatric Association 2015, pp 8-9). As in community settings, mid-level providers (i.e., nurse practitioners and physician assistants) are commonly employed as prescribers in correctional settings. However, psychiatrists are essential as clinicians and supervisors in these settings to provide leadership for multidisciplinary teams and support the delivery of quality care.

Juveniles are housed in detention settings pre-adjudication and rarely while awaiting disposition. Youths enter detention because they are deemed to be at high risk of committing new crimes, have committed homicide or sexual assault, have not made required court appearances, or when there are no suitable alternatives. Minorities are disproportionately detained in such facilities (Rodriguez 2013).
State psychiatric hospitals have significant proportions of forensic patients with commitments related to criminal justice involvement. Nearly fifty percent of state psychiatric hospital beds were occupied by forensic patients in 2016 (Fuller et al. 2016). The presence of so many individuals with justice involvement has challenged traditional treatment environments.

Forensic patients are typically hospitalized on an involuntary status. Further, they may receive involuntary treatment that some see as coercive and counter to recovery. Public intolerance and social stigma contribute to barriers that limit patient centered care in this setting. Despite these challenges, forensic

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hospitals, and correctional settings in general, are indeed compatible with recovery paradigms (Pinals and Andrade 2015).

3) Many opportunities exist for effective treatment of patients with mental illness in criminal justice settings.

Mentally ill patients with criminal justice involvement frequently encounter challenges accessing systems of care. Services in the community are often highly fragmented. Many individuals fall through the cracks when released from custody or hospitalization. These challenges contribute to high rates of recidivism and impact public health and safety.

Increasing awareness of the large number of persons with serious mental illness housed in correctional facilities (Baillargeon et al. 2009) has spurred considerable efforts to prevent or minimize incarceration of the mentally ill and to reduce recidivism rates through various interventions. Opportunities for psychiatrists to participate in, or help develop, intervention and treatment are available at several points in time, including the prearrest or pre-booking phase, the post-arrest or post-booking phase, drug and mental health courts, during incarceration, and upon reentry into the community from jails, prisons, and hospitals (Munetz and Griffin 2006; DeMatteo et al. 2013; Brown 2010).

A promising option for diverting defendants with mental illness from incarceration is the use of specialty probation. In contrast to traditional probation, specialty probation officers receive mental health training, have reduced caseloads comprised exclusively of clients with mental illness, and have more frequent contacts with probationers and their case managers and treatment providers (Petrilla and Redlich, 2007; DeMatteo et al 2013). Results of several studies suggest that specialty probation is more effective that traditional probation in linking probationers with mental health services, improving their well-being, and lowering their risk of probation violations (American Psychiatric Association 2016).

According to the American Psychiatric Association (APA), the primary goal of treatment within correctional settings is to "provide timely access to mental health services to all inmates who need them" in order to relieve suffering and impairments caused by mental illness, to enhance the safety of inmates and others, and to improve inmates' ability to participate in educational, treatment, and other programs (National Commission on Correctional Health Care 2015). Detailed guidelines for the provision of psychiatric services in correctional facilities have been published by several organizations, including the APA and the National Commission on Correctional Health Care (National Commission on Correctional Health Care 2015; McKee and Penn 2014). Basic elements of an adequate treatment system include adequate staffing (including nursing, medical and mental health staff), a process for thorough mental health screening and diagnostic evaluation, and a continuum of treatment modalities ranging from pharmacological treatment to various forms of psychotherapy.

In addition to pharmacotherapy for treatment of certain mental disorders, various forms of individual and group psychotherapy appear to be useful in the correctional setting. For example, there is promising evidence that cognitive-behavioral therapy in particular is helpful in treating a broad spectrum of socially problematic behaviors using techniques such as anger control management and social skills training (Milkman and Wanberg 2007; Kersten et al 2015).

Another promising practice is telepsychiatry. Telepsychiatry connects inmates with an off-site psychiatrist primarily through videoconferencing. Because many jails and prisons are located in rural or isolated areas, telepsychiatry can provide timely access to specialty care without incurring the staff and transportation

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costs and safety risks related to transporting inmates. When creating a telepsychiatry program, several considerations are important, including HIPAA-compliant transmission (i.e., encryption), appropriate patient selection, and an appropriate site for the patient to sit during consultation (American Psychiatric Association 2016).

A critical role for psychiatry is assisting patients with mental illness to re-integrate into the community following their release from a correctional setting (DeMatteo et al. 2013). Released prisoners suffering from mental health problems require immediate and ongoing mental health services in order to successfully reenter the community and avoid re-arrest (La Vigne et al. 2008). There is now widespread agreement that transition planning (also referred to as discharge planning or release planning) is essential to facilitating continuity of care for soon- to-be released inmates with mental illness (Baillargeon, Hoge, Penn 2010). Reentry programs typically involve collaborations between correctional systems, the courts, community mental health systems, probation/parole departments, and other community-based agencies (Draine and Herman 2007; Jarrett et al. 2012).

There are many points throughout an individual's interaction with the criminal justice system where interventions can occur to ensure that individuals with mental illness are identified and provided appropriate care. These interventions can lead to decreasing the criminalization of mental illness as well as improving clinical outcomes. For example, many incarcerated individuals receive their first formal psychiatric treatment and/or diagnosis after arrest, some while experiencing their first episode of psychosis. Evidence indicates that early and coordinated intervention at this early stage can dramatically improve clinical prognosis, even if in a jail or prison (Ford, 2015). Psychiatrists working in the criminal justice system have an opportunity to help individuals with mental illness receive effective treatment, alleviate suffering, and reduce recidivism.

Services that combine mental health treatment with interventions targeting criminogenic risk factors may be necessary to reduce recidivism in justice-involved individuals with mental illness. Mental illness and criminality are co-occurring issues warranting therapeutic intervention much like co-occurring mental illness and substance abuse (Morgan et al. 2010). Psychiatrists have an opportunity to play an important role in slowing the revolving door and helping people make significant life course revisions as they navigate the challenges that justice involvement brings.

4) The opportunities for educating medical students, residents and fellows in correctional psychiatry are extraordinary.

Psychiatrists are under-represented in correctional settings yet are the only professionals who are both trained and licensed to provide all aspects of mental health treatment, from psychotherapeutic interventions to complicated psychopharmacology (Reingle, Gonzalez and Connell 2014). Psychiatrists are frequently the leaders in mental health care and tend to be highly respected in the paramilitary structure of law enforcement agencies that manage jails and prisons. An important step is to increase the educational opportunities for medical and psychiatric trainees in this field and more robustly introduce jails and prisons as training sites (Trestman, Ferguson, Dickert 2015). To meet this goal, educational initiatives for medical students, residents, and fellows should reflect the changing landscape of psychiatry outside the traditional setting of community clinics or hospital units.

The introduction and/or expansion of clinical and didactic experiences related to the treatment of individuals with mental illness in jails and prisons into medical and psychiatric education is a critical step toward advancing our knowledge and competence in caring for this often overlooked population.

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5) There are great professional opportunities.

Given the demand for correctional psychiatrists created by the increasing numbers of mentally ill persons incarcerated in the United States, compensation for correctional work is usually quite competitive. The clinical problems encountered by correctional psychiatrists are diverse, complex and frequently fascinating. Working in a setting where there is limited access to illegal substances and where adequate food, clothing, and shelter are available provides psychiatric practitioners with an opportunity to achieve improved clinical outcomes that are not always achievable in a community setting. Diverse treatment modalities are needed in correctional settings, including pharmacological management of psychiatric illness, psychotherapy, substance use treatment and detoxification, crisis intervention, trauma based therapies, and group therapies (cognitive therapies, dialectical behavioral therapy, recovery therapy, process groups and community reentry groups). The APA has published a resource document entitled "Psychiatric Services in Correctional Facilities" that provides useful guidelines for psychiatrists working in correctional facilities (APA 2016). With such a wide range of opportunities, psychiatrists can usually tailor their job descriptions to their particular area of clinical interest. Additionally, those with interests and skills in administration can help build resources and design models of treatment that will achieve good clinical outcomes, support successful recovery, and reduce recidivism. Correctional psychiatrists are in a unique position to assure that patients are treated with dignity, receive rehabilitation, and are free from discrimination and abuse.

Correctional psychiatrists, particularly those with broader forensic backgrounds and training, practice at the nexus of medical, legal, and ethical issues regarding psychiatric treatment for those involved in public health and correctional systems. For example, one issue that comes up often in the correctional system is the patient who is declining treatment with medication. With an understanding of both case law and clinical research, correctional psychiatrists are in a unique position to advocate, if necessary, for appropriate involuntary treatment, ensuring that medications are utilized for clinical purposes rather than for convenience (e.g., sedation) and in the process, mitigate adverse outcomes and manage medical-legal risk.

Psychiatrists working with justice involved populations can channel their clinical expertise to administrative prowess, providing informed – and pragmatic – guidance to state, county, and local officials determining how best to treat a growing population of incarcerated persons with mental illnesses. To that end, they will generally carry knowledge of case law, policies and practice that can help guide others. In this way, correctional psychiatrists have the unique opportunity to positively impact the lives of incarcerated persons with mental illnesses and promote public safety by increasing access to quality mental health care, both in correctional facilities and at the interface of the public mental health services in the community.

6) The benefits of choosing this career are numerous, and should counter commonly felt reservations about choosing a career in correctional psychiatry.

The choice to practice as a psychiatrist in a correctional setting should not be made lightly. Environmental challenges exist (e.g., controlled entrances and exits, law enforcement presence, generally remote locations, lack of modern amenities and onsite internet/library access). Couple that with perhaps the most

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stigmatized patient population in this country (justice-involvement, mental health and substance use disorders, minority and/or low socioeconomic status). This requires that a psychiatrist have a strong mission for patient care, a deep respect for clinical excellence, a desire to improve the human condition, and a capacity for work within a complex system.

Common concerns about working in correctional settings include limited clinical autonomy, personal safety, and access to continuing education. However, practice within these settings is not constrained by insurance mandates (or paperwork), and depending on the facility, allows for a potentially wider array of creative and innovative treatments than in other settings. Even where formulary requests are a challenge (as they are in all public settings), there are often opportunities to work with medical leadership to access appropriate care, and there are opportunities to work with medical leadership to influence policy and practice in meaningful ways. Further, many correctional settings have already established, or are preparing to establish, links with academic medical centers that bring a vibrant educational experience, through training programs and didactics, to the psychiatric staff in jails, prisons and juvenile facilities (Trestman, Ferguson, Dickert 2015).

Another common concern relates to personal safety in working in this environment. Though there is little published on this subject, the consensus experience of the Authors is that the risk of a psychiatrist being assaulted or injured in a jail or prison setting, where security is a primary objective, is lower than in busy emergency rooms or some inpatient hospital settings. Safety policies and protocols are typically well established and openly discussed.

Taken together, the concerns that some would articulate do not tend to be robust in real practice. Providing mental health care to justice-involved populations can introduce young and experienced psychiatrists alike to complicated pathology that is not frequently seen elsewhere, patients who can be profoundly grateful for help and administrative and leadership opportunities that are unparalleled.

Conclusions

So, why should more psychiatrists participate in the treatment of justice-involved patients? The fact is that correctional settings are now large community and public psychiatry practices and state hospitals are forensic settings. In the wake of deinstitutionalization and reduction of civil beds, as well as stringent drug crime legislation, jails and prisons are the new psychiatric hospitals and house many of our patients at critical points in their lives. We genuinely have the opportunity to impact the lives of these patients who are among the most disadvantaged. From a practice perspective, it is among the safest of community settings for psychiatrists to deliver care, it provides excellent compensation, and the work provides profound professional satisfaction.

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