Commentary: Bridging the Gaps for Former Inmates with Serious Mental Illness

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Serious mental illness is a prominent and vexing problem within the correctional systems of North America. Simpson and colleagues draw attention to the epidemiology, special characteristics, and management problems relevant to Canadian inmates with serious mental illness. Of great interest to those in the forensic psychiatric field is the matter of continuation of care for mentally ill prisoners, in that untreated or undertreated psychiatric problems are strongly associated with poor social functioning and criminal recidivism. In this commentary, we expand on the discussion in Simpson *et al.* of the effectiveness of assertive community treatment teams for those former inmates at greatest risk for future involvement with the criminal justice system. We also propose outpatient civil commitment as one strategy to facilitate the successful return of select inmate patients to the community.

J Am Acad Psychiatry Law 41:510–3, 2013

Simpson and colleagues[1] draw our attention to the epidemiology, special characteristics, and management of inmates with a serious mental illness (SMI) within the Canadian prison system. We think that this article identifies important shared clinical and academic interests for correctional psychiatrists in both the United States and Canada. First and foremost is their conclusion that SMI is common in correctional settings. As the authors point out, the seriously mentally ill are more likely to be incarcerated than admitted to a hospital[2–4] for treatment. The corollary to this conclusion, confirmed by epidemiological research in both the United States and Canada, is that SMI is more prevalent in a correctional setting than it is in the community.[5–9] As the SMI represent those most in need of psychiatric care for poor functioning, whether in a community[10] or a prison setting,[11] meeting these needs is critically important to all stakeholders.

Some aspects of the review by Simpson *et al.* limit its generalizability to prison systems. Most relevantly, their use of the term prison inmate refers to both pretrial detainees and those serving a sentence after criminal adjudication. Thus, data are included in their review on inmates who might be housed in a jail or detention center. Although the article at times points out which type of inmate was included in the cited study, interpretation of this information requires awareness of the differences between pretrial and sentenced inmates. First, the rate of mental illness in general, and serious mental illness in particular, may be moderately higher in jails than it is in prison. The most recent survey by the Bureau of Justice comparing the rate of mental illness in U.S. jails and prisons illustrates this point: psychotic symptoms were reported by approximately 24 percent of jail inmates versus 15 percent of state prisoners.[12] A second, related point mentioned by Simpson *et al.* includes the acuity level of mental illness in these two populations. Pretrial detainees are more likely to experience symptoms of their illness, given the predictable psychosocial stressors related to their recent incarceration and the uncertainty about their legal fate. The stress of their situation may explain the higher suicide rate observed in jails compared with that in prisons.[13] Finally, although substance abuse was not the focus of Simpson *et al.*, the rate of substance use disorders appears to be higher in inmates in jail than in their counterparts in state prison.[14]

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Disclosures of financial or other potential conflicts of interest: None.

It is hard to argue about the point that Simpson and colleagues make that SMI is a major problem for correctional psychiatrists and the systems in which they serve. The untreated or undertreated mentally ill are at greater risk for unemployment, homelessness, needing emergency services or hospitalization, substance abuse, suicide, being victims of crime, engaging in violence toward others, and poor quality of life.[15,16] They have a shorter life expectancy, most likely related to a combination of undertreated medical problems, unhealthful lifestyle, suicide, accidents, and victimization by others.[17] The mortality of persons with SMI is much higher than would be expected after release to the community, most often related to drug overdose, cardiovascular disease, suicide, and homicide.[18] Notwithstanding the moral imperative and professional duty of physicians and other mental health workers to alleviate suffering and reduce risk, the treatment of mental illness in incarcerated individuals is mandated by the U.S. Constitution[19] and by federal regulations in Canada.[20]

We have no doubt that a prison sentence has saved the lives of some persons with serious mental illness. It is not uncommon to hear of a returning inmate patient who did not connect with aftercare services (or dropped out of treatment), became noncompliant with medication, and resumed using illegal substances as a prelude to violating parole or committing another crime. Whether incarcerated or in the community, patients with SMI may lack the insight, understanding, or appreciation of their condition that is necessary to make a well-reasoned decision to accept or decline health care services. As discussed by Simpson *et al.*, Lennox *et al.*[21] reported that only 4 of 53 SMI patients with an aftercare plan including the involvement of a Community Mental Health Care team were still in contact with their team six months after release. Despite the fact that prisoners with SMI are often lost to follow-up, Simpson *et al.* highlight the important role that mental health providers in correctional settings play in preparing their patients to return to society. Discharge (or re-entry) planning has long been regarded as a standard of care by the National Commission for Correctional Health Care[22] and the American Psychiatric Association.[23]

Simpson *et al.* describe the use of assertive community treatment (ACT) teams in re-entry planning for former Canadian inmates with SMI, but they point out that traditional ACT services have not yet been shown to reduce recidivism.[24,25] They suggest that the forensic assertive community treatment (FACT) model may be better, with a focus on pretrial diversion by taking referrals from jails, adding probation officers to the team, providing housing assistance, and offering treatment for comorbid substance use disorders. Similar specialized programs geared toward the re-entry of SMI patients may also show promise. For instance, the Forensic Transition Team (FTT) in Massachusetts seeks to attend to the needs of persons with SMI exiting the correctional system and offers coordinated care services to both pretrial and sentenced inmates. Despite the voluntary nature of the program, outcome data[26] show that 46 percent of former inmates with SMI were engaged in services after three months in the community. Of interest, patients who had misdemeanor charges for which they typically served six to nine months were the most likely to be lost to follow-up and to return to the criminal justice system.

Prison systems have advantages over other settings for the management of patients with SMI who are unwilling or unable to accept necessary psychiatric treatment voluntarily. Convicted individuals in the United States may be eligible for involuntary psychiatric medication in an administrative procedure modeled after *Washington v. Harper*.[27] These inmates may be asymptomatic or greatly improved as they approach release, thanks to structure created by the presence (or likelihood) of nonemergency forced medication. When released from prison, they are no longer subject to the findings of a *Washington v. Harper*-type panel. Local civil regulations for forced medication are typically stricter and usually require inpatient civil commitment. Given the stability brought about by forced medication in prison, many of these patients will not meet criteria for inpatient civil commitment. Although some jurisdictions such as California have a formal process for the civil commitment of inmates with SMI who would otherwise be a danger in the community,[28] such processes are the exception rather than the rule. Civil commitment imposes restrictions on liberty grievous enough, and different enough vis-à-vis incarceration, to deserve additional due process.[29] The typically strict standards for inpatient civil commitment often render hospitalization a short-term solution for those who, with treatment, will not become dangerous in the foreseeable future.[30] Even when psychiatric medications mitigate the symptoms and behavioral prob-

lems associated with SMI, improvements in insight and judgment may lag behind other gains.

For select cases, involuntary outpatient commitment (IOC) may close the gaps in legal protections that create a revolving door of hospital and correctional recidivism. Most provinces in Canada have provisions for outpatient commitment in the Community Treatment Order (CTO). CTOs in Ottawa have been shown to reduce the number and duration of inpatient stays and to increase access for SMI patients to housing and mental health services.[31] Outpatient commitment is legal in 45 states, although its implementation in the United States has been inconsistent.[32] The best example of the benefits of outpatient commitment in the United States is New York's Kendra's Law or assisted outpatient treatment (AOT). Research has shown that outpatient commitment reduces arrests, the number of hospitalizations, inpatient length of stay, homelessness, violent acts, and suicidal behavior; improvements were noted in medication compliance and social functioning.[33–36] For those enrolled in AOT for at least seven months, these improvements were maintained even after the patient was no longer mandated to outpatient treatment by court order.[37] We believe that outpatient commitment, especially when it links former inmates with SMI to intensive treatment services, community support, and housing, would be a formidable tool to reduce recidivism and improve health care outcomes.

Involuntary outpatient treatment is not without controversy. A Cochrane review in 2011 concluded that the existing evidence from randomized controlled trials on outpatient commitment at the time was weak regarding outcome measures such as reducing hospital admissions, homelessness, and arrests.[38] Criticisms of outpatient commitment include concerns about inadequate funding, diversion of public funds away from voluntary outpatient services, liability associated with managing dangerous persons outside of a hospital, unwillingness of judges and police to enforce the conditions of outpatient commitment, and the violation of a patient's rights by using coercion to enforce compliance.[32,39] Economic analyses to date suggest that, even with the cost of providing comprehensive outpatient services pursuant to Kendra's Law in New York State, such services are cost effective[32] and need not siphon resources from voluntary outpatient services.[40] Similar to inpatient commitment, civil rights are protected by jurisdiction-specific criteria and the need for a court order for outpatient commitment. Whether a patient is appropriate for outpatient commitment is a clinical judgment requiring the same level of skill necessary for decisions to medicate, to reduce observation status, or to discharge from the hospital. It does not replace the option to hospitalize, but rather allows for the management of appropriate patients who are stable with treatment (yet reluctant to comply), in a less restrictive environment. Psychiatrists, especially forensic psychiatrists, can play a role in educating law enforcement and the judiciary about outpatient commitment and in advocating for appropriate enforcement.

Other strategies to alleviate the burden of serious mental illness in correctional facilities may also be worth considering. Mental health courts authorized to order a person with SMI into treatment in lieu of incarceration have shown promise for reducing recidivism and violence.[41–43] Warrants for emergency room evaluations of suspected seriously mentally ill persons, such as the emergency petition process in Maryland, may serve as an early diversion from the correctional system.[44] A postconviction approach would be to coordinate with the parole department when developing an aftercare plan for an inmate with SMI. Defining treatment compliance as a condition of parole could have the same effect as outpatient commitment in reducing recidivism for those former inmates apt to respond to structured consequences for noncompliance. The difference unfortunately is that a violation of parole would be expected to result in reincarceration, rather than potential hospitalization in the event of a violation of the terms of an outpatient treatment order. Simpson *et al.* point out research showing that those with SMI are already at greater risk of recidivism because of technical violations of parole.[45]

In summary, we agree that serious mental illness in correctional settings in North America is a common and important problem. Bridging the effective management of SMI from the prison clinics to treatment centers in the community has implications for general and forensic psychiatrists in all settings. Providing comprehensive community services for these patients, whether through FACT teams, outpatient civil commitment, mental health courts, or other creative means, is a promising approach to maximizing functioning and minimizing risk, at the least possible cost to civil liberties for those already well familiar with not being free.

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