Psychopharmacology in Jails: An Introduction

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If you are interested in part-time correctional work, the best place to start is often the local jail—as opposed to a prison. What's the difference between the two? A jail is a criminal justice facility operated by a city or county. It houses people who are awaiting trial or who have received short sentences, typically one year or less. In contrast, a prison is operated by a state (or the federal government) and houses inmates who are usually serving long sentences for felonies. Virtually every county has some type of jail facility, often located in large cities. Prisons, on the other hand, are usually remote from urban centers, making part-time employment less feasible.

There is a high demand for psychiatric care in U.S. correctional facilities. At any given time, about 1% of the adult population is incarcerated (Appelbaum PS, Psychiat Serv 2011;62:1121–1123), and many of them have a psychiatric disorder of some sort. One study found that 49% of jail inmates had symptoms of both mental illness and a comorbid substance abuse disorder (James DJ and Glaze LE, Mental health problems of prison and jail inmates. Washington, DC: Bureau of Justice Statistics; 2006. www.bjs.gov/content/pub/pdf/mhppji.pdf), while other studies have found rates of severe mental disorders, including psychotic disorders, bipolar disorder, and major depression, ranging from 10% to 27% of jail and prison inmates (Lamb HR et al, Psychiat Serv 2007;58:782–786).

Diagnostic challenges

Jail psychiatry tends to be fast-paced; for example, your initial intake interview will probably be 30 minutes or less with each new patient. Newly arrived inmates are often very tired and irritated. Many were homeless and abusing drugs or alcohol prior to arrest, and have spent hours waiting in lines, holding tanks, or court lock-ups. They may be very annoyed about having been arrested. By the time they cross your path a day or two after being picked up by the police, they often don't want to engage in a lengthy interview. This reluctance may continue at your followup visits, when you will have even less time to spend with them.

Diagnosing jail inmates poses special challenges. There are various complicating factors, including severe and chronic substance abuse, medical comorbidities, developmental delay and/or low education, personality disorders, and secondary gain issues. While many inmates are legitimately in need of psychiatric care, you will run across others who do not have severe mental illness or even any diagnosis, but who are embellishing, exaggerating, or outright manufacturing psychiatric symptoms for a variety of reasons. The motivations for this kind of malingering vary. Medication-seeking is common, though you might be surprised at what medications are abused in jail—more on that later. Some inmates may also view you as a way to receive a diagnosis that might shield them from impending punishment for an infraction of jail rules. Others may be hoping you can get them moved to a different part of the jail to avoid threats from other inmates or for opportunities to pass along messages.

Jailhouse prescribing: Art and science

There is one key factor that makes prescribing in a jail setting more challenging than prescribing in a community environment: The selection of medications in your toolbox is severely limited. Given the high rates of substance abuse disorders in the incarcerated population, you will rarely, if ever, prescribe potentially abused drugs. This issue is most relevant to patients who present with ADHD, anxiety, or insomnia.

ADHD

ADHD in jail inmates may be left untreated as many jails won't allow you to prescribe stimulants. Atomoxetine (Strattera) is a potential choice, although it may not be on formulary, thus requiring the prescriber to go through a prior approval process. Off-label alternatives, such as venlafaxine (Effexor), are sometimes helpful, especially if a patient has both ADHD and depression or anxiety.

Anxiety and insomnia

Avoid benzodiazepines due to their high risk of abuse and diversion. For anxiety (and depressive symptoms), your primary go-to meds will be selective serotonin reuptake inhibitors (SSRI) such as sertraline (Zoloft) and citalopram (Celexa), as well as the non-SSRI mirtazapine (Remeron). While waiting for these to start working in an anxious patient, you might offer antihistamines such as diphenhydramine (Benadryl) or hydroxyzine (Atarax, Vistaril). These are also commonly used to treat insomnia. High doses of diphenhydramine, up to 150 mg or even 200 mg qhs, are surprisingly well-tolerated by many inmates— perhaps because many have abused sedating substances in the past and have developed tolerance to their effects. You will have to be cautious about prescribing trazodone to a male inmate, due to the risk of a delay in access to appropriate medical care if the inmate develops priapism. Obviously, this is not a concern for female inmates.

On the topic of sexual side effects, you will discover that many male inmates, especially the younger ones, are particularly bothered by the sexual dysfunction induced by SSRIs. For this reason, you are likely to find that you are prescribing mirtazapine much more than you do in your community practice. Many inmates appreciate its sedating qualities, and they often do not mind the side effect of increased appetite. These factors are less relevant for female inmates, who for the most part do not care about decreased libido while in jail, but who are just as concerned about weight gain as are women in the community.

Commonly abused medications

At this point, you may be wondering why I have not mentioned bupropion (Wellbutrin) as an option either for depression or as a non-stimulant alternative for ADHD. While bupropion does not hold much attraction as a drug of abuse in the "free world," it is one of the most commonly abused medications in jails and prisons. Inmates stockpile doses to take several at once, sometimes crushing the pills and snorting them, to obtain an amphetamine-like high. Bupropion is so sought-after that it is a form of currency, bartered like cigarettes once were before the smoke-free era. For this reason, most jail psychiatrists are very wary of prescribing it, and some institutions have removed it from their formularies. Venlafaxine (Effexor) can also be abused for a stimulant-like rush, but this is significantly less common and only the more savvy inmates are aware of the abuse potential.

Buspirone (BuSpar) might seem like a good option as a non-habit forming treatment for anxiety, but it is also abused by jail inmates, though not to the same extent as bupropion. Gabapentin (Neurontin) also has a tendency to be abused, and is not available in many correctional facilities. For medications with potential for abuse or diversion, if you absolutely need to give them, you can either order a liquid formulation, or if there is no liquid form, order it to be crushed and mixed in water or juice (or another medication that is available in liquid form that the patient is also taking) prior to administration.

When it comes to antipsychotic medications, in addition to all of the typical antipsychotics such as fluphenazine (Prolixin) and haloperidol (Haldol), most jails will have on formulary several of the standard atypicals, including aripiprazole (Abilify), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon). You will quickly discover that quetiapine rivals bupropion as an abused medication. Inmates prize its effects on sleep, and it also seems to provide a relaxing effect. Many inmates will claim to have psychotic symptoms in an effort to obtain quetiapine. For some reason, they don't seem as interested in olanzapine.

Treating psychosis

Sadly, American jails house a significant number of people with schizophrenia (Lamb HR and Weinberger LE, J Am Acad Psychiatry Law 2013;41:287– 293). Many have not committed significant crimes, but have been arrested for minor offenses like trespassing. This population tends to be homeless and to have particularly poor insight into their illness and need for treatment. In order to counter their tendency to "cheek" and then spit out their medications, you will often use liquid or crushed antipsychotics. For similar reasons, the liquid form of the mood stabilizer valproic acid (Depakene) is a good choice in patients with mania, despite being more irritating to the stomach than divalproex sodium (Depakote). In addition, a mood stabilizer like valproic acid/divalproex, or perhaps oxcarbazepine (Trileptal), is often used for inmates who don't have classic symptoms of bipolar disorder but who are agitated and aggressive, whether due to schizophrenia, traumatic brain injury, developmental disability, severe personality disorder, PTSD, or an impulse-control disorder.

What if your patient with psychosis demonstrates poor compliance with medication? If it is a matter of poor insight and lack of motivation to report for pill call, a long-acting injectable antipsychotic may be a good choice. However, it is critical to realize that jail inmates have the same right to refuse medication as any outpatient. Thus, if your patients refuse medication, you won't be able to force them to comply. Although jails can have varying policies about patients who require involuntary medications, most of the time these patients must be transferred to a hospital setting. If you are working in a large jail, the facility may have a licensed hospital section where patients can be involuntarily hospitalized and given medications.

Conclusion

There are many unique and complicated aspects of diagnosing and prescribing in jail. I touched on some of the more important issues in this article, but space constraints prevented a discussion of managing suicidality, aggression, and detox (for more information on correctional psychiatry, a good resource is *Psychiatric Services in Correctional Facilities* 3e. American Psychiatric Association. Arlington, VA: 2015). You'll also learn a lot about treating inmates on the job, especially as you discuss cases with colleagues, including correctional staff, other mental health professionals like psychologists and social workers, and psychiatrists. It's likely that you will find the work to be intellectually stimulating, extremely interesting, and professionally rewarding.

Case example: Is This Inmate Malingering?

Your patient is a muscular man in his late 40s. He reports that he is hearing and seeing things because he doesn't have his medications. He is able to engage in conversation, his thought process is linear, and he does not appear distracted by hallucinations. He says his regular medications are "Seroquel, Wellbutrin, Depakote, and Xanax." He then says that he can't be housed with anyone else (ie, he needs a single cell) because he becomes paranoid, thinks others are trying to kill him, and would get into a fight with a cellmate.

The patient goes on to tell you that he receives SSI disability for mental illness and lives in a board-and-care home. You quickly scan the electronic medical record of his previous stays in your facility and find that during one of them he was prescribed risperidone. You ask him for more details of his hallucinations. He tells you that when he stares at your desk he sees "strippers," then starts laughing.

As you consider your treatment plan, you suspect that there is an element of malingering in the patient's presentation. He describes atypical visual hallucinations which do not bother him, and his linear thought process and intact attention are not particularly consistent with a diagnosis of schizophrenia. Three of the medications he claims to take are notorious drugs of abuse in jail (quetiapine, bupropion, and alprazolam).

On the other hand, he is requesting divalproex sodium, which is not a medication that inmates typically seek out. In addition, he appears somewhat agitated, and his repeated arrests, receipt of SSI, and placement in a board-and-care home suggest genuinely impaired function.

In jail, the distinction between authentic symptoms and malingering is rarely black and white. You decide that the patient is most likely exaggerating the hallucinations and the paranoid ideation in an effort to obtain two things: his preferred medications and a safer housing location. However, you also conclude that he most likely does have some type of treatable condition, perhaps bipolar disorder, antisocial or other personality disorder, and/or an impulse control disorder. Since he mentioned divalproex, you decide to start by prescribing that, with a plan to observe him over time to see if his behavior is more consistent with a genuine psychosis or if it reveals evidence more consistent with exaggerated or manufactured psychotic symptoms.