



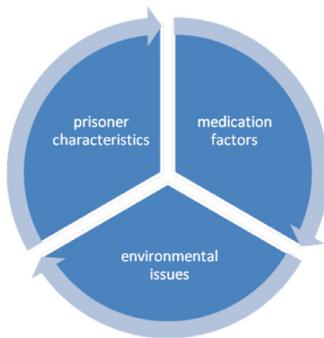
Corrections & Mental Health

An Update of the National Institute of Corrections



Volume 1, Number 1

Psychiatric Medication Adherence Among People Who Are Incarcerated *What Do We Know?*



Sticking to the Prescription

According to a recent literature review, three factors—prisoner characteristics, medication factors, and environmental issues present in the prison system—influence psychiatric medication adherence among people in correctional facilities.

the most current information on psychiatric medication adherence during incarceration, Deborah Shelton, Ph.D., R.N., F.A.A.N., and colleagues reviewed literature published on the topic between 1973 and 2009. After reducing the number of papers to include only those focused on the correctional population, they found nine articles specifically investigating the relationship of psychiatric medication adherence among inmates.

Influences On Adherence

“Most of reasons for non-adherence for prisoners are similar to those of patients in the community but with the overlay of the prison environment,” says Shelton. Patient characteristics, prior use of psychiatric medication, insight into need for medication, side effects, and the prison or parole environment all influence adherence. “From the literature and what we know clinically, non-adherence is related to patient characteristics—younger people are typically less adherent than those that are older, whites tend to be the most adherent, and people with diagnoses of paranoid schizophrenia less so,” Shelton explains.

Perhaps one of the best capabilities mentally ill people can develop while incarcerated is the willingness to stick with a medication regimen and take self-care measures because they realize it helps them. The motivation and ability to adhere to psychiatric medication is essential to transitioning from prison to the community. When prisoners with mental illness do not develop good medication adherence and self-care management skills during incarceration, however, they run the risk of being psychiatrically unstable at release—leading to high rates of recidivism, hospitalization, and extensive use of correctional and mental health resources. This is also a public safety issue, as low medication adherence is linked with violence.

Despite the high percentage of incarcerated persons with mental illness and the importance of medication adherence to effective treatment—taking about 80 percent of a prescription, according to the American Psychiatric Association (APA)—surprisingly little is known about patterns and ways to increase this behavior in prison and upon release. To identify

Involuntary Medication— A Difficult Question

Non-adherence to medication regimens among mentally ill prisoners and parolees is perceived to have a wider impact on society because it can increase the risk of violence and recidivism. However, balancing the goals of appropriate care for the prisoner, prisoners' rights, and community safety can be difficult. These issues have prompted some to consider involuntary psychiatric medication for mentally ill people in correctional care.

The prison environment can further complicate medication adherence. “In correctional care, communication of prisoner status regarding medications prescribed and the importance of dispensing medication as ordered is not a small task. Medication may need to come from another building, may not be available as medication is limited to formulary supply, security level may not allow the prisoner to receive medication at the assigned time, or a host of other reasons may affect whether the prisoner receives a particular medication,” the authors note. Although these factors affect medication adherence, the behavior is not static and can change in response to interventions or programming changes.

“Our latest longitudinal research suggests that both the right medication for the right diagnosis and regular contact with clinicians are critical drivers of medication adherence among the mentally ill,” says Shelton. “When inmates can see the benefits of medication at controlling symptoms, like everyone else, they are willing to tolerate side effects and show better adherence.”

Sometimes the prison environment hinders adherence by increasing the impact of side effects. For example, directions may indicate that a medication should be taken with food to limit side effects. But this may not be easy to do in the highly structured prison environment.

“The corrections environment may limit one’s ability to exercise choice and self-care management for taking medications,” Shelton says. Efforts to improve adherence must be adapted for these environments, she adds. Identifying the factors that influence adherence, in turn, reveals steps institutions can take to improve this important behavior among inmates. Some systems have nurses out in the units, which tends to improve assessment and care, Shelton says. “In my experience, correction professionals are amenable to hearing about evidence and practical approaches to improvements to solve problems like medication adherence. One has to understand that they must consider safety first, but they are generally willing to make small changes for good reasons.”

Suggestions To Improve Adherence

Correctional clinicians play a crucial role in risk assessment for non-adherence at intake (gauging factors such as past adherence and readiness to change), and they can suggest appropriate interventions as well, the authors note. One way to assist prisoners in sticking with their medications is to help them develop insight into the essential importance of daily adherence even when their symptoms have abated. “People do better when they have insight that the medication must be taken regardless of how they feel, but the high rate of cognitive limitations—for example, from chronic alcohol or drug abuse to undiagnosed head trauma—among individuals in corrections can make insight-development challenging,” says Shelton.

This is where the structured environment and supervision of correctional environments can help. Prisoners who have supervision, support, and regular contact with a clinician demonstrate better medication adherence than those without such structures supporting pharmaceutical compliance. Developing prisoner self-care also offers an enormous opportunity to improve medication adherence, Shelton says.

Motivational, educational, and behavioral strategies tailored for community-based psychiatric populations could also be adapted to the prison environment and tested for effectiveness. For example, a motivational-interviewing framework in combination with the stages-of-change approach is now being applied for medication adherence among mentally ill individuals in the outside community. Medication reminders in the form of visual aids also support adherence. Shelton and colleagues have developed and

“Undoubtedly, some people need medication—and it’s good that pharmacotherapy, diagnosis, and evidence-based practice have improved,” says Shelton. “This issue has to be looked at individually and with care. Such individuals need both medication and behavioral treatment. Medication stabilizes symptoms and clears the mind for other forms of treatment. The system can support access to medication for people who need it, but a concern is that the care of corrections patients is complex and resources are stretched thinly.”

“This is a question of protecting both sides—prisoners with mental illness and the public,” says Shelton. “If the system has exercised the appropriate protections for the public, I do not see any reason to medicate people involuntarily. Medication is a type of restraint, and we should think about it that way. It is best to use the least form of restraint.”

“There is a need to monitor prisoners’ psychiatric conditions and provide the best care, and medication is not the only treatment. Researchers are testing evidence-based treatments, such as rehabilitation and cognitive-behavioral therapy, in the corrections environment. Most of what is available in corrections is group and cognitive therapy, and there is room for other treatments—including nutrition management, expressive arts therapy, writing, and strengths building,” says Shelton.

are currently testing a self-care management model for the prison population. “It is not just about giving them information about their medications, but helping them use resources correctly and supporting self-care. Such efforts can be effective and cost-effective,” she says.

In these efforts, coordination of care among correctional physicians, nurses, and other professionals is essential. In addition to the APA definition of adherence referred to earlier, the concept also includes proper doses and duration of medication treatment. Correctional staff need training—even in the form

of simple written information—on the importance of psychiatric medication, side effects, signs and symptoms of non-adherence, and the necessity of prompt intervention in non-adherence cases. Such coordination of care has been found to be

“With effort and persistence, good communication, and an understanding of the prisoner’s goals and concerns, a working relationship [regarding medication adherence] with the prisoner can be reached.”—*Shelton et al., 2010*

effective for assisting prisoners adhere to their medication regimen, the authors say. “Generally, coordination of care in any health care system is always facilitated by a mandate as well as leaders who advocate for it,” Shelton says. “It is essential to find the ‘win-win’ for all the players involved in the effort for it to work.”

Adherence After Release

Developing prisoner insight and self-care behaviors may boost the likelihood of continued adherence once inmates leave the highly structured environment of prison, but many will need additional support. Upon release, correctional facilities try to connect patients at high medical risk (for example, those that are mentally ill or diabetic) with community health care services so patients can continue taking the medications they used during incarceration. Different systems have different approaches—some give a prescription, some give a 2-week supply of medication, along with teaching patients about their medications.

“Despite the release or discharge plan for medications, problems occur when people have no support in the community,” says Shelton. “There are not enough inside-outside transitional programs—which start while the person is still incarcerated and involve a professional who also helps the individual link up with community services—which are most effective at improving adherence.” Although having help navigating the transition from prison to community in the area of psychiatric medications may help adherence, patients often run into larger challenges. “Systems issues, such as loss of health care insurance during incarceration and the need to get it back upon release, can make continuing medication after prison difficult,” Shelton adds.

