Current PSYCHIATRY

Caring for patients on probation or parole

Promoting stability in the community can reduce recidivism and re-incarceration

Mr. A, age 35, presents to your outpatient community mental health practice. He has a history of psychosis that began in his late teens. Since then, his symptoms have included derogatory auditory hallucinations, a recurrent persecutory delusion that governmental agencies are tracking his movements, and intermittent disorganized speech. At age 30, Mr. A assaulted a stranger out of fear that the individual was a government agent. He was arrested and experienced a severe psychotic decompensation while awaiting trial. He was found incompetent to stand trial and sent to a state hospital for restoration.

After 6 months of treatment and observation, Mr. A was deemed competent to proceed and returned to jail. He was subsequently convicted of assault and sentenced to 7 years in prison. While in prison, he received regular mental health care with infrequent recurrence of minor psychotic symptoms. He was released on parole due to his good behavior, but as part of his conditions of parole, he was mandated to follow up with an outpatient mental health clinician.

After telling you the story of how he ended up in your office, Mr. A says he needs you to speak regularly with his parole officer to verify his attendance at appointments and to discuss any mental health concerns you may have. Since you have not worked with a patient on parole before, your mind is full of questions: What are the expectations regarding your communication with his parole officer? Could Mr. A return to prison if you express concerns about his mental health? What can you do to improve his chances of success in the community?

continued

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Patients on probation or parole

Clinical Point

Probationers and parolees who do not engage in psychiatric treatment when it is a condition of their release face re-incarceration

Given the high rates of mental illness among individuals incarcerated in the United States, it shouldn't be surprising that there are similarly high rates of mental illness among those on supervised release from jails and prisons. Clinicians who work with patients on community release need to understand basic concepts related to probation and parole, and how to promote patients' stability in the community to reduce recidivism and re-incarceration. The court may require individuals on probation or parole to adhere to certain conditions of release, which could include seeing a psychiatrist or psychotherapist, participating in substance abuse treatment, and/or taking psychotropic medication. The court usually closely monitors the probationer or parolee's adherence, and noncompliance can be grounds for probation or parole violation and revocation.

This article reviews the concepts of probation and parole (***Box***,[1,2] ***page 29***), describes the prevalence of mental illness among probationers and parolees, and discusses the unique challenges and opportunities psychiatrists and other mental health professionals face when working with individuals on community supervision.

Mental illness among probationers and parolees

Research on mental illness in people involved in the criminal justice system has largely focused on those who are incarcerated. Studies have documented high rates of severe mental illness (SMI), such as schizophrenia and bipolar disorder, among those who are incarcerated; some estimate the rates to be 3 times as high as those of community samples.[3,4] In addition to SMI, substance use disorders and personality disorders (in particular, antisocial personality disorder) are common among people who are incarcerated.[5,6]

Comparatively little is known about mental illness among probationers and parolees, although presumably there would be a similarly high prevalence of SMI, substance use disorders, and other psychiatric disorders among this population. A 1997 Bureau of Justice Statistics (BJS) survey of approximately 3.4 million probationers found that 13.8% self-reported a mental or emotional condition and 8.2% self-reported a history of an "overnight stay in a mental hospital."[7] The BJS estimated that there were approximately 550,000 probationers with mental illness in the United States. The study's author noted that probationers with mental illness were more likely to have a history of prior offenses and more likely to be violent recidivists. In terms of substance use, compared with other probationers, those with mental illness were more likely to report using drugs in the month before their most recent offense and at the time of the offense.[7]

More recent research, although limited, has shed some light on the role of mental health services for individuals on probation and parole. In 2009, Crilly et al[8] reported that 23% of probationers reported accessing mental health services within the past year. Other studies have found that probationer and parolee engagement in mental health care reduces the risk of recidivism.[9,10] A 2011 study evaluated 100 individuals on probation and parole in 2 counties in a southeastern state. The authors found that 75% of participants reported that they needed counseling for a mental health concern in the past year, but that only approximately 30% of them actually sought help. Individuals reporting higher levels of posttraumatic stress disorder symptomatology or greater drug use before being on probation or parole were more likely to seek counseling in the past year.[11]

An alternative: Problem-solving courts

Problem-solving courts (PSCs) offer an alternative to standard probation and/or sentencing. Problem-solving courts are founded on the concept of therapeutic jurisprudence, which seeks to change "the behavior of litigants and [ensure] the future well-being of communities."[12] Types of PSCs include drug court (the most common type in the United States), domestic violence court, veterans court, and mental health court (MHC), among others.

Box

Probation and parole in the United States

The US Bureau of Justice Statistics (BJS) defines probation as a "court-ordered period of correctional supervision in the community, generally as an alternative to incarceration." Probation allows individuals to be released from jail to community supervision, with the potential for dismissal or lowering of charges if they adhere to the conditions of probation. Conditions of probation may include participating in substance abuse or mental health treatment programs, abstaining from drugs and alcohol, and avoiding contact with known felons. Failure to comply with conditions of probation can lead to re-incarceration and probation revocation.[1] If probation is revoked, a probationer may be sentenced, potentially to prison, depending on the severity of the original offense.[2]

The BJS defines parole as "a period of conditional supervised release in the community following a term in state or federal prison."[2] Parole allows for the community supervision of individuals who have already been convicted of and sentenced to prison for a crime. Individuals may be released on parole if they demonstrate good behavior while incarcerated. Similar to probationers, parolees must adhere to the conditions of parole, and violation of these may lead to re-incarceration.[1]

As of December 31, 2016, there were more than 4.5 million adults on community supervision in the United States, representing 1 out of every 55 adults in the US population. Individuals on probation accounted for 81% of adults on community supervision. The number of people on community supervision has dropped continuously over the last decade, a trend driven by 2% annual decreases in the probation population. In contrast, the parolee population has continued to grow over time and was approximately 900,000 individuals at the end of 2016.[2]

An individual may choose a PSC over standard probation because participants usually receive more assistance in obtaining treatment and closer supervision with an emphasis on rehabilitation rather than incapacitation or retribution. The success of PSCs relies heavily on the judge, as he/she plays a pivotal role in developing relationships with the participants, considering therapeutic alternatives to "bad" behaviors, determining sanctions, and relying on community mental health partners to assist participants in complying with conditions of the court.[13-15]

Psychiatrists and other mental health clinicians should be aware of MHCs, which are a type of PSC that provides for the community supervision of individuals with mental illness. Mental health courts vary in terms of eligibility criteria. Some accept individuals who merely report a history of mental illness, whereas others have specific diagnostic requirements.[16] Some accept individuals accused of minor violations such as ordinance violations or misdemeanor offenses, while others accept individuals accused of felonies. Like other PSCs, participation in an MHC is voluntary, and most require a participant to enter a guilty plea upon entry.[17] Participants may choose to enter an MHC to avoid prison time or to reduce or expunge charges after completing the program. Many MHCs also assign a probation officer to follow the participant in the community, similar to a standard probation model. Participants are usually expected to engage in psychiatric treatment, including psychotherapy, substance abuse counseling, medication management, and other services. If they do not comply with these conditions, they face sanctions that could include jail "shock" time, enhanced supervision, or an increase in psychiatric services.

Outpatient mental health professionals play an integral role in MHCs. Depending on the model, he/she may be asked to communicate treatment recommendations, attend weekly meetings at the court, and provide suggestions for interventions when the participant relapses, recidivates, and/or decompensates psychiatrically. This collaborative model can work well and allow the clinician unique opportunities to educate the court and advocate for his/her patient. However, clinicians who participate in an MHC need to remain aware of the potential to become a de facto probation officer, and need to maintain appropriate boundaries and roles. They should ensure that the patient provides initial and ongoing consent for them to communicate with the

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Clinicians who participate in an MHC have the potential to become a de facto probation officer, and need to maintain boundaries

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Do not assume that someone who has been incarcerated has antisocial personality disorder

court, and share their programmatic recommendations with the patient to preserve the therapeutic alliance.

Challenges upon re-entering the community

Individuals recently released from jail or prison face unique challenges when re-entering the community. An individual who has been incarcerated, particularly for months to years, has likely lost his/her job, housing, health insurance, and access to primary supports. People with mental illness with a history of incarceration have higher rates of homelessness, substance use disorders, and unemployment than those with no history of incarceration.[7,18] For individuals with mental illness, these additional stressors lead to further psychiatric decompensation, recidivism, and overutilization of emergency and crisis services upon release from prison or jail. The loss of health insurance presents great challenges: when someone is incarcerated, his/her Medicaid is suspended or terminated.[19] This can happen at any point during incarceration. In states that terminate rather than suspend Medicaid, former prisoners face even longer waits to re-establish access to needed health care.

The period immediately after release is a critical time for individuals to be linked with substance and mental health treatment. Binswanger et al[20] found former prisoners were at highest risk of mortality in the 2 weeks following release from prison; the highest rates of death were from drug overdose, cardiovascular disease, homicide, and suicide. A subsequent study found that women were at increased risk of drug overdose and opioid-related deaths.[21] One explanation for the increase in drug-related deaths is the loss of physiologic tolerance while incarcerated; however, a lack of treatment while incarcerated, high levels of stress upon re-entry, and poor linkage to aftercare also may be contributing factors. Among prisoners recently released from New York City jails, Lim et al[22] found that those with a history of homelessness and previous incarceration had the highest rates of drug-related deaths and homicides in the first 2 weeks after release. Non-Hispanic white men had the highest risk of drug-related deaths and suicides. While the risk of death is greatest immediately after release, former prisoners face increased mortality from multiple causes for multiple years after release.[20-22]

Clinicians who work with recently released prisoners should be aware of these individuals' risks and actively work with them and other members of the mental health team to ensure these patients have access to social services, employment training, housing, and substance use resources, including medication-assisted treatment. Patients with SMI should be considered for more intensive services, such as assertive community treatment (ACT) or even forensic ACT (FACT) services, given that FACTs have a modest impact in reducing recidivism.[23]

Knowing whether the patient is on probation or parole and the terms of his/her supervision can also be useful in creating and executing a collaborative treatment plan. The clinician can assist the patient in meeting conditions of probation/parole such as:

- creating a stable home plan with a permanent address
- planning routine check-ins with probation/parole officers, and
- keeping documentation of ongoing mental health and substance use treatment.

Being aware of other terms of supervision, such as abstaining from alcohol and drugs, or remaining in one's jurisdiction, also can help the patient avoid technical violations and a return to jail or prison.

How to best help patients on community supervision

There are some clinical recommendations when working with patients on community supervision. First, do not assume that someone who has been incarcerated has antisocial personality disorder. Behaviors primarily related to seeking or using drugs or survival-type crimes should not be considered "antisocial" without additional

evidence of pervasive and persistent conduct demonstrating impulsivity, lack of empathy, dishonesty, or repeated disregard for social norms and others' rights. To meet criteria for antisocial personality disorder, these behaviors must have begun during childhood or adolescence.

If a patient does meet criteria for antisocial personality disorder, remember that he/she may also have a psychotic, mood, substance use, or other disorder that could lead to a greater likelihood of violence, recidivism, or other poor outcomes if left untreated. Treating any co-occurring disorders could enhance the patient's engagement with treatment. There is some evidence that certain psychotropic medications, such as mood stabilizers or selective serotonin inhibitors, can be helpful in the off-label treatment of impulsive aggression.[24] However, practitioners should combine pharmacologic treatment with nonpharmacologic interventions that directly address criminogenic thinking and behaviors, and use external incentives (such as the patient's desire to not return to prison or jail) to promote desired, pro-social decision-making.

In addition to promoting patients' mental health, such efforts can prevent re-arrest and re-incarceration and make a lasting positive impact on patients' lives.

CASE CONTINUED

Mr. A signs a release-of-information form and you call his parole officer. His parole officer states that he would like to speak with you every few months to check on Mr. A's treatment adherence. Within a few months, you transition Mr. A from an oral antipsychotic medication to a long-acting injectable antipsychotic medication to manage his psychotic disorder. He presents on time each month to your clinic to receive the injection.

Five months later, Mr. A receives 2 weeks of "shock time" at the local county jail for "dropping a dirty urine" that was positive for cannabinoids at a meeting with his parole officer. During his time in jail, he receives no treatment and he misses his monthly long-acting injectable dose.

Upon release, he demonstrates the recurrence of some mild persecutory fears and hallucinations, but you resume him on his prior treatment regimen, and he recovers.

You encourage the parole officer to notify you if Mr. A violates parole and is incarcerated so that you can speak with clinicians in the jail to ensure that Mr. A remains adequately treated while incarcerated.

In the coming years, you continue to work with Mr. A and his parole officer to manage his mental health condition and to navigate his parole requirements in order to reduce his risk of relapse and recidivism. After Mr. A completes his time on parole, you continue to see him for outpatient follow-up.

continued

Related Resources

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Clinical Point

There is some evidence that certain psychotropic medications can be helpful in the off-label treatment of impulsive aggression

Bottom Line

Clinicians may provide psychiatric care to probationers and parolees in traditional outpatient settings or in collaboration with a mental health court (MHC) or forensic assertive community treatment team. It is crucial to be aware of the legal expectations of individuals on community supervision, as well as the unique mental health risks and challenges they face. You can help reduce probationers' and parolees' risk of relapse and recidivism and support their recovery in the community by engaging in collaborative treatment planning involving the patient, the court, and/or MHCs.

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Combine pharmacologic treatment with nonpharmacologic interventions that directly address criminogenic thinking

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