THE CARLAT REPORT PSYCHIATRY

A CME Publication

AN UNBIASED MONTHLY COVERING ALL THINGS PSYCHIATRIC

Daniel Carlat, MD
Editor-in-Chief
Volume 14, Number 5
May 2016
www.thecarlatreport.com

IN THIS ISSUE

Focus of the Month:
Correctional Psychiatry

Learning Objectives
After reading these articles, you should be able to:
1. Describe the main differences between practicing psychiatry in a correctional facility compared to a traditional care environment. **2.** Detail some of the challenges in prescribing medications to inmate patients. **3.** Summarize some of the current findings in the literature regarding psychiatric treatment.

Psychopharmacology in Jails: An Introduction

Joe Simpson, MD, PhD, supervising psychiatrist at the Los Angeles County DMH Jail Mental Health Services, CA

Dr. Simpson has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

In Summary

- Diagnosis of imprisoned patients is more challenging than usual because of potential malingering.
- Medication choices for common psychiatric conditions are often different in jail because of formulary issues, abuse potential, and other factors.
- Commonly abused medications in jails include bupropion, buspirone, gabapentin, and quetiapine.

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

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Q&A With the Expert

The Experience of Correctional Psychiatry
Patrick Gariety, MD

Psychiatrist at Group Health Behavioral Health Services, WA

Dr. Gariety has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCPR: Dr. Gariety, please tell us a bit about your background.
Dr. Gariety: I've been in practice for 23 years, starting out in community mental health, followed by 13 years in the federal bureau of prisons. Currently I work for a large regional medical group in the private sector.
TCPR: Tell me a bit more about the correctional setting.
Dr. Gariety: I worked at a high-security prison hospital, one of several medical/psychiatric centers within the federal bureau of prisons. There were about 1,200 prisoners at our facility. Several hundred were simply serving their time there, and the rest were either medical or psychiatric patients received from other prisons or jails. There were about 300 psychiatric patients at our facility, staffed with five psychiatrists and eight psychologists. Our staff included forensic clinicians who conducted court-ordered evaluations, and clinicians who did actual treatment. I was a treatment clinician. The psychiatric population was extremely mixed, with most of our patients suffering from some form of chronic mental illness, and/or severe personality disorders.

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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 follow-up 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

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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

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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.

Expert Interview
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TCPR: What was your day-to-day job treating patients like?

Dr. Gariety: As you entered the institution each morning, you passed through a security gauntlet not unlike what you experience at the airport. Treatment was carried out by three multidisciplinary treatment teams. Our caseload consisted of 2 types of patients: those residing in locked housing (aka "solitary confinement") and those in the general population (GP). The patients in GP could freely access their doctor, whereas patients in lockup couldn't. Our work day typically began with morning report, attended by all disciplines, including correctional staff. Following report, our team's psychologist and I would always do rounds on the locked housing units. We were somewhat atypical in committing ourselves to daily rounds on the locked units, but we felt it an essential priority which served both patients and staff in immeasurable ways. Rounding would often take up much of our mornings; afternoons were given to charting, writing orders, and individual talk therapy. At any time in the day, the routine was susceptible to emergencies requiring immediate attention, which usually occurred several times a week. This might be as innocuous as a patient in lockup becoming loud and disruptive, to something as serious as a suicide attempt or a medical emergency.

TCPR: So the GP patients would be the equivalent of civilian "outpatients," and the lockup patients would be more like our "inpatients."

Dr. Gariety: Essentially, yes. Patients in GP could freely move about the institution and access their doctor, whereas patients in locked housing couldn't. The assumption was that GP patients didn't pose a threat or a danger. They could come to my office at any time. With that being said, you always used your best judgment and listened to your gut as to whether or not to see an inmate in your office. My office was located where there was a lot of inmate and staff floor traffic. For privacy purposes, people couldn't hear us, but they could easily see us via a window in my door. And we had instant access to security by phone or radio.

TCPR: How did it work seeing patients in locked housing?

Dr. Gariety: Rounding on a locked unit meant going from cell to adjacent cell, pressing your ear into the cell's doorjamb while peering through a security-glass window, and talking through the doorjamb. The conversation you were having with the inmate was freely available to any interested staff or other nearby inmates who cared to listen in. As unconducive as this sounds, it's where the majority of the most valuable talk therapy happened. Rounds also provided a means to role-model for the benefit of correctional staff.

"The prison asylum I worked in was tough and challenging, but it was also often gratifying work. It offered an opportunity to safely work with very ill patients in-depth in a manner that I can't imagine in any other practice setting."

Patrick Gariety, MD

TCPR: That's interesting. How does that help correctional staff?

Dr. Gariety: Partly, it helps show how to de-escalate aggressive or psychotic behavior. But more importantly, it was a means of continually strengthening your alliance with the officers, who could be your best friends—or your worst enemies. Nothing earned more credibility with officers, or their respect, as much as their seeing you doing daily rounds and extending yourself to both patients and correctional staff alike. That alliance was essential to effectively working in a prison setting.

TCPR: I assume that daily rounds could be pretty time-consuming?

Dr. Gariety: Yes, but it was time well spent. The most disturbed individuals are in lockup, and it disincentivized a lot of their acting out and bad behavior knowing that they were going to see their doctor at least once every workday. It was a way of minimizing problems down the road.

TCPR: What was locked housing like?

Dr. Gariety: They were typically like what you see in the movies: two-tiered housing units where you walk onto an open area and the perimeter is lined by cells. You walk up some steps, and there is a catwalk accessing the second level. The cells are about 9' x 6' single cells with a cot, commode, and a sink. There is a security door with security glass, and there's a slot that can be opened to pass things back and forth—food trays and other things.

TCPR: Were patients in lockup confined to their cells all day?

Dr. Gariety: Not necessarily. They were entitled to one hour of recreation outside their cell on most days, but for the rest of the day they were locked up except when permitted to shower. They were "rec'ed" (allowed recreation) outdoors, in chain-linked security pens. They submitted to wrist restraints anytime they were escorted from their cells to the rec cage area or to showers. Higher-functioning patients would routinely avail themselves of rec periods outside their cells, but some of the more paranoid and impaired patients took recreation infrequently, if at all. Or, if they'd misbehaved in some way, correctional staff might take it upon themselves to confine them to their cells and not offer them rec. For example, the officers might get fed up if a patient routinely defecated in his rec cage and decide to impose their own discipline, even though the patient wasn't a danger to anybody—he was just being a nuisance.

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Expert Interview
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TCPR: You mention recreational cages. Are they literally cages?

Dr. Gariety: Yes and no. They're not as small as what you're probably envisioning. They're large chained-link enclosures, topped with razor wire, big enough to jog in a tight circle within it.

TCPR: It sounds pretty frightful.

Dr. Gariety: It is. Prisons are vast repositories of human suffering, which over the past several decades have become *de facto* asylums for the most seriously mentally ill, typically far removed from their families and communities of origin. Prisons aren't designed to be therapeutic. In fact the dominance of law enforcement culture exacerbates mental illness (and sometimes, likely causes it) in numerous ways. The best example of this, in my opinion, is its over-utilization of prolonged solitary confinement. A significant percentage of the patients we cared for weren't sentenced inmates, but rather were civilly committed to federal care. A good number of these civilly committed patients were sufficiently stabilized that they no longer were in need of prison hospital custody, but they couldn't be released due to a lack of adequate resources in the community, ie, supervised housing—a horrible catch-22.

TCPR: What was the most interesting patient you encountered?

Dr. Gariety: The most interesting patients, by virtue of being so far removed from my prior practice experience, were transgender inmates to whom I provided feminizing hormone replacement therapy (one of my transgender patients castrated herself, in her prison cell, prior to successfully suing the Federal Bureau of Prisons for the right to initiate hormone therapy). The most sensational, vexing, and difficult patients were individuals who engaged in chronic self-injurious behaviors of all sorts: self-cutting, self-impaling, head-banging, foreign object swallowers, and people who stuck foreign bodies up every conceivable body orifice. Water intoxicators (psychogenic polydipsia) were also a big challenge in the prison population I worked with.

TCPR: What are some of the positive aspects of working in the prison system?

Dr. Gariety: The prison asylum I worked in was tough and challenging, but it was also often gratifying work. It offered an opportunity to safely work with very ill patients in-depth in a manner that I can't imagine in any other practice setting. Treatment extended over months to decades. In terms of continuity and long-term inpatient care, it offered opportunities that are (tragic to say) fast disappearing outside the prison system. I enjoyed the tremendous heterogeneity of the population, and the wide variety of psychiatric problems I was presented with. I relished the fact that I was part of a multidisciplinary care team. I never felt like I was acting alone in the care of our patients. Many of our patients were profoundly personality disordered, and I shudder at the thought of having had to treat them without the benefit of other colleagues' eyes on the patient and the treatment plan. I find professional isolation to be stressful in and of itself, regardless of how "sick" or "well" our patients are.

TCPR: It sounds like you could really get to know your patients.

Dr. Gariety: I would see nearly everyone on my caseload daily—if only by crossing paths with them while rounding on other patients. This is in contrast with my current outpatient practice, where I see a patient every several months for a 20- to 30-minute med check. Every morning in report, we had all disciplines providing patient updates, so I was always hearing things through other people that allowed me to keep tabs on how my patients were doing. In terms of safety issues, I worry more about the safety of my current outpatients than I did about my prison patients.

TCPR: In what way?

Dr. Gariety: I didn't worry as much about suicide with my correctional patients. I knew each of them well, and it was a relatively easy and routine thing to put someone on suicide watch. In the community, that's not at all the case. Perhaps a majority of my outpatients have some degree of suicidality, and I worry about them a lot. So, in terms of stress, it was easier to manage that aspect of the job in the correctional setting.

TCPR: You work in a civilian care organization now—what are some of the key differences from the prison system?

Dr. Gariety: In the prison system, I worked closely with a multidisciplinary treatment team in delivering care. We were given a fair amount of autonomy in making decisions. Insurance companies and billing codes didn't exist. In my current job, the emphasis is on maximizing productivity and finessing E&M codes to maximize reimbursement. My clinical focus is narrow, and near exclusively relegated to psychotropic medication prescription. It's more isolating than my prison work, and I find it less interesting. I have little sense of being part of a wider multidisciplinary milieu.

TCPR: Any final thoughts?

Dr. Gariety: The main challenge I faced in working with prisoners was making a human connection with individuals who were used to being treated as less than human, and who typically had no reason to trust anyone employed by the prison. You had to be willing and able to meet them, wherever they were, even and especially in places of rage and hostility. For lots of inmates, this meant our willingness to stop at their cell door each time we passed by, and engaging with respect and genuine concern. This typically didn't make any dent in their mental illness, and often didn't do anything to change their chances of getting out of lockup, but it did mean a great deal to them to be treated with humanity. Recognizing the value of this required a shift away from only thinking about patients in terms of cure and change, to the more humbling stance of caring, even with the most clinically hopeless cases.

TCPR: Thank you for your time, Dr. Gariety.

Research Updates IN PSYCHIATRY

Section Editor, Bret A. Moore, Psy.D, ABPP

Dr. Moore has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

ELECTROCONVULSIVE THERAPY

Ongoing ECT Does Not Equal Ongoing Cognitive Problems

(Kirov G et al, *BJ Psych* 2016;208:266–270)

Electroconvulsive therapy (ECT) is well known to cause short-term amnesia and disorientation around the time of treatment. However, for most of our patients, these cognitive side effects improve and disappear fairly quickly, usually within a few days. We have less information about how long-term ECT may affect our patients, such as those who have had multiple courses over the years, or those who have undergone maintenance monthly treatments. A recent study provides us with some reassuring data.

Cardiff University researchers collected cognitive performance data on 199 ECT patients over a 10-year period. The main goal was to see if repeated or ongoing courses of ECT caused cumulative cognitive problems. The researchers were also interested to know if other factors such as age, days since last ECT session, and depression severity played a role in any cognitive decline.

Nine cognitive tests measuring recognition, working memory, verbal fluency, processing speed, and mental status were given at three time points: prior to the start of ECT, within 1 week after treatment completion, and at 3 months follow-up. Those who received multiple courses of ECT were tested again at the same intervals. Those who required maintenance ECT (>50 sessions) were tested yearly. The total number of ECT sessions patients received prior to the testing was also recorded.

The analysis showed that the total number of ECT sessions had no effect on performance on any of the cognitive tests given to patients. The factors that did decrease performance were greater age and more severe depression. However, a longer time gap since the last ECT session was associated with improved performance.

TCPR's Take: Many patients are concerned about the long-term effects of ECT. While this study is not definitive, since it is not a randomized controlled study, it is highly suggestive that long-term ECT, including maintenance treatments, does not significantly impair cognition.

PREGNANCY

Second-Generation Antipsychotics Do Not Raise Risk of Major Malformations

(Cohen L et al, *JAMA Psychiatry* 2016;173:263–270)

Second-generation antipsychotics (SGA) are used for a variety of psychiatric conditions, but even though they've been around for 20 years, we know little about what impact they have on the developing fetus. These medications are widely considered to be relatively safe during pregnancy, but this assumption is based on scant evidence. In this paper, researchers tapped into the Massachusetts General Hospital (MGH) National Pregnancy Registry of Atypical Antipsychotics and reported some reassuring results.

Over a six-year period, 214 women between the ages of 18 and 45 who had been exposed to an SGA during their first trimester were enrolled. These women were compared to a control group of 89 women who had a psychiatric illness during pregnancy, and who were treated with psychiatric medications but who were not exposed to an SGA. The women were interviewed at three time points: time of enrollment in the registry, 7 months pregnant, and 3 months post-partum. Medical records were also reviewed. There were a few differences between the two groups: notably 24% of SGA-exposed women smoked, compared to only 10% of women in the control group. SGA-exposed women were also twice as likely to also be exposed to an anticonvulsant (40% vs 19%). Interestingly, the majority of women (about 60%) in both groups had a primary diagnosis of bipolar disorder, and only a small proportion (about 2%) carried a primary diagnosis of schizophrenia.

In the exposed group, the risk of developing a serious malformation was 1.4% (3 of 214 births); in the unexposed group, the risk was 1.1% (1 of 89 births). The researchers concluded that SGAs are unlikely to be teratogenic, but that the study sample is too small to reach a definite conclusion. They point out that the MGH registry continues to collect data on this issue, and that as the sample size increases, they will likely be able to estimate the risk with more precision.

TCPR's Take: SGAs probably do not increase the risk of serious fetal malformations, which is reassuring. It's important to note that the study did not report on less serious effects, such as higher birthweight, neonatal withdrawal, or even gestational diabetes. Prior studies of SGAs have shown possible associations with these outcomes, so counseling pregnant women about these meds remains complicated.

CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. Jail inmates are likely to abuse which atypical antipsychotic medication? (Learning Objective #2)
   [ ] a. Ziprasidone [ ] b. Risperidone [ ] c. Asenapine [ ] d. Quetiapine

2. The best example of how prisons exacerbate or cause mental illness is: (LO #1)
   [ ] a. Rigid law enforcement culture complicating humane healthcare provision
   [ ] b. Removing individuals from their families and communities of origin
   [ ] c. Providing limited patient programming opportunities
   [ ] d. Over-reliance on and over-utilization of prolonged solitary confinement

3. According to Dr. Simpson, which off-label alternative to stimulants can be helpful in treating ADHD in inmates that also have depression or anxiety? (LO #2)
   [ ] a. Bupropion [ ] b. Hydroxyzine [ ] c. Venlafaxine [ ] d. Diphenhydramine

4. According to Dr. Gariety, many civilly committed inmates remain in prison hospital custody for which of the following reasons? (LO #1)
   [ ] a. Denial of parole
   [ ] b. Prolonged solitary confinement
   [ ] c. Lack of adequate support resources in the community
   [ ] d. Lack of psychiatrists at correctional facilities

5. A recent study showed that long-term electroconvulsive therapy causes more cognitive impairment than short-term treatment. (LO #3)
   [ ] a. True [ ] b. False

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Correctional Psychiatry: Salary and Benefits Are Generous

Daniel Carlat, MD, Publisher, The Carlat Psychiatry Report

The average annual wage for U.S. psychiatrists in 2015 is about $194,000 (U.S. Bureau of Labor Statistics). According to a 2011 salary survey, the average salary of a prison psychiatrist in the U.S. is $204,909 (https://www.salaryexpert.com/salary-surveydata/job=prison-psychiatrist/salary). Further breaking this down by state, here are some salary figures for psychiatrists working in a correctional setting:

- New York: $200,147 (includes overtime)
- Texas: $220,000 (not including overtime)
- Florida: $230,711 (not including overtime)
- California: $248,172 (not including overtime or extra duty) (mdsalaries.com)

And these averages are probably on the low side. For example, a recent search for a state correctional psychiatrist in California showed an opening for a chief psychiatrist position offering an annual salary range between $268,176 and $332,378 (http://www.cphcs.ca.gov/). With a lack of psychiatrists, overtime, should you choose to take it, can be quite lucrative. In 2009, one of the highest paid state correctional clinicians in California made 31% of his $450,000 yearly salary from overtime.

In general, you should add to these salaries a comprehensive benefits package that includes medical, dental, and life insurance; malpractice insurance; paid holidays; sick days; and vacation time. Sign-on bonuses and loan repayment can also be part of the package. And when it's time to leave your position, you will receive a lump sum for any unused accrued vacation time, which can amount to a huge bonus, potentially in the low to mid 6 figures. In addition, remember that thing called a pension? You're likely to get that too.

THE CARLAT REPORT: PSYCHIATRY

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This Month's Focus:
Correctional Psychiatry

Next month in *The Carlat Psychiatry Report:* Psychoanalysis

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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.

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