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Clinician Perspectives for Mental Health Delivery Following COVID-19 in Carceral Settings: A Pilot Study

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Abstract
We aimed to understand clinician perspectives on mental healthcare delivery during COVID-19 and the utility of tele-mental health services in carceral settings. A survey was administered in November 2022 through the American College of Correctional Physicians listserv. A nationwide sample of 55 respondents included 78.2% male (n=43) and 21.8% female (n=12), 49.1% active clinicians (n=27) and 50.9% medical directors (n=28), with a median of 12 and mean of 14.5 years working in carceral settings. Most agreed that mental telehealth services could serve as a stopgap amid infection prevention measures and resource-limited settings with an increasing role moving forward (80.0%, n=44) but may not be sufficient to replace in-person services completely. Access to mental healthcare is vital in helping achieve optimal health during incarceration. Most clinicians in a nationwide survey report an essential role of mental telehealth in the future, although they vary in beliefs on the present implementation. Future efforts should further identify facilitators and barriers and bolster delivery models, particularly via e-health.

Keywords Correctional health · Psychiatry · Telemedicine · e-health

Introduction

Individuals involved with the criminal legal system experience an elevated burden of mental illness, including higher rates of depression, anxiety, and attempted suicides than the general public [1, 2]. Factors inherent to carceral settings – solitary confinement, isolation from society, and little interaction with friends and family – contribute to this burden [3, 4]. A considerable resource gap exists to address these challenges, such as screenings by those not professionally trained in mental health and shortages of medical professionals [5]. Further, the reincarceration rate is 50–230% higher for legal system-involved individuals with mental health conditions than those without [1]. Mental health care in carceral settings is a unique clinical area with inherent legal and administrative barriers to care and treatment [6]. The intricate, bidirectional relationship between mental health and incarceration highlights

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the importance of mental healthcare access within carceral settings to improve personal health outcomes.

COVID-19 exacerbated these long-existing mental health challenges. There were higher rates of mental illness among incarcerated populations than in the general public during COVID-19 [7]. In-person visitations were limited, prisoners were more isolated, and interactions with family and friends were halted [8]. Telepsychiatry emerged as a possible solution to provide continued access to care. Burton and colleagues describe the implementation of telepsychiatry in San Quentin State prison, the site of one of the largest COVID-19 outbreaks of 2020 [8]. They characterize the benefits of tele-mental health, including high satisfaction in patients and staff, the ability to avoid close contact with others amidst the pandemic, high efficiency of care, and the conservation of the prison's PPE supply [8]. Additional cited benefits have included reduced need to transport prisoners, alleviation of the effects of staffing shortages, and reduced operational costs [9]. However, there are notable drawbacks and limitations associated with telepsychiatry. These include perceived reduced quality of care, high cost and investment associated with new technology, limited technical assistance for patients, and reduced awareness of the patient's environment compared to on-site providers [5, 8, 9].

More broadly, the prominence of tele-mental health has steadily been increasing over the previous decade. From 2010 to 2017, the number of US mental health facilities that offered tele-mental health services doubled. Furthermore, its implementation was most apparent across this period in rural and medically underserved areas [10]. With the onset of the pandemic, there was an unprecedented adoption of tele-mental health. In a study surveying 903 practitioners, more than 80% of surveyed providers had shifted to tele-mental health practices by early April 2020, compared to only 20% in December 2019. This trend was seen across psychiatrists, psychologists, and social workers. Nearly 60% of those surveyed suggested they would continue to provide tele-mental health in the future [11]. Similarly, telehealth utilization has seen steady implementation within carceral settings over the previous decades, with studies indicating numerous economic and cost-saving benefits to its use within this population [12]. This increasing incidence applies to tele-mental health services as well [13]. While tele-mental health utilization is well documented for carceral settings in individual studies during the COVID-19 pandemic, [5, 8, 9, 14] quantitative metrics characterizing its incidence over this time are sparse.

There remain important medico-legal and ethical considerations with the increased uptake of telepsychiatry. The pandemic also saw the removal of regulatory hurdles to tele-mental health's widespread use, such as restrictions on the prescription of controlled substances and limitations on insurance reimbursements [15]. These changes have significantly altered the landscape of mental health care for all patients and providers and will have profound implications on the field moving forward. Ethical arguments favoring tele-mental health have included improved access to care, flexibility, and economic advantages such as reduced healthcare costs for patients and therapists. Conversely, ethical issues raised against the adoption of tele-mental health include privacy and confidentiality concerns, communication issues inherent to telecommunication, and lack of research on its use [16].

Considering the ongoing nature of the pandemic, the unmet mental health burden among incarcerated individuals, and the variable benefits and limitations described concerning telepsychiatry, our study aims to supply the perspectives of a nationwide sample of car-

ceral health clinicians to specifically characterize the mental health crisis during COVID-19 alongside the role and utility of telepsychiatry in carceral settings.

Methods

We invited correctional health clinicians within the American College of Correctional Physicians (ACCP) listserv to complete an online survey between November 1, 2022 and November 29, 2022, with weekly follow-up emails. The survey consisted of structured questions and a qualitative free-response section on experiences with mental healthcare delivery during COVID-19 and perspectives on tele-mental health. We aggregated data, collected demographic statistics, and collated qualitative responses. Seven participants were selected to win $25 gift card. The Icahn School of Medicine Institutional Review Board approved this study.

To devise our non-validated survey instrument, we first conducted a literature review to identify topics or formulate questions relevant to mental healthcare access (e.g. medico-legal considerations, stigma, logistical challenges) and telemedicine (e.g., a survey of telemedicine services among veterans) [17]. We then developed a preliminary questionnaire with iterative refinement through consultation with our research team, which includes a board-certified psychiatrist and attorney who conducts research in forensic psychiatry (JMA). We finally obtained feedback from correctional health physicians within the ACCP organization. ACCP is the largest organization of its kind internationally focused on the professional development of correctional clinicians; its efforts focus on research, education, and correctional medicine training [18]. The ACCP has 507 members, including 323 physicians, 64 PA/NP/DDS/PharmD/DPM/OD/Mental Health Professionals with a Doctorate Degree, 39 residents, and 81 students.

Results

Our sample (n=55 respondents) was 78.2% male (n=43) and 21.8% female (n=12) and from across the United States: 16.4% NE (n=9), 21.8% Midwest (n=12), 32.7% South (n=18), 23.6% W (n=13), and 5.5% other (n=3). Respondents were 49.1% medical directors (n=27) and 50.9% active clinicians (n=28), 32.7% family medicine by training (n=18), with a median of 12 and mean of 14.5 years working in carceral settings. (Table 1)

Respondents (Table 2) largely viewed incarcerated patients as experiencing overall more stress (83.6%, n=46). In terms of mental healthcare delivery, 38.2% (n=21) of respondents reported reduced services, 30.9% (n=17) reported continued in-person services, and 36.4% (n=20) reported hybrid services. Regarding potential tele-mental health relative to in-person care, 47.3% (n=26) of respondents believed it to be lower quality than in-person care with masks and 34.5% (n=19) found it to be equivalent. However, a majority (80%, n=44) of respondents found an increasing role for tele-mental health moving forward.

Most respondents rated the audibility of encounters (54.5%, n=30), ensuring patient safety and confidentiality (63.6%, n=35), and receiving full workload credit for appointments (58.2%, n=32) as not a challenge for tele-mental health in carceral settings (Fig. 1). A majority rated establishing rapport with the patient (47.3%, n=26) and assessing the physi-

Table 1 Participant Characteristics

Age	
21–30	1.8% (n=1)
31–40	14.5% (n=8)
41–50	9.1% (n=5)
51–60	27.3% (n=15)
61–70	29.1% (n=16)
71–80	10.9% (n=6)
81–90	7.3% (n=4)
Gender	
Male:	78.2% (n=43)
Female:	21.8% (n=12)
Occupation	
Active Clinician:	50.9% (n=28)
Medical Director:	49.1% (n=27)
Retired:	14.5% (n=8)
Administrator:	5.5% (n=3)
Specialty	
Family Medicine	32.7% (n=18)
Other	27.2% (n=15)
General Internal Medicine	18.1% (n=10)
Psychiatrists	12.7% (n=7)
Emergency Medicine	9.1% (n=5)
Number of Years working with Correctional Populations	
Median:	12
Mean:	14.5
Range	1–45
Correctional Settings Previously Worked	
Prison	61.8% (n=34)
Jail	52.7% (n=29)
Other	23.6% (n=13)
Current Work	
Prison	50.9% (n=28)
Jail	30.9% (n=17)
Other	27.2% (n=15)
Current Region:	
Northeast:	16.4% (n=9)
Midwest:	21.8% (n=12)
South:	32.7% (n=18)
West:	23.6% (n=13)
Other:	5.5% (n=3)

cal health status (47.3%, n=26) as somewhat of a challenge. A moderate proportion rated seeing the patient adequately (43.6%, n=24), difficulty using device and/or using video telehealth platforms (49.1%, n=27), lack of technical support/training for providers (47.3%, n=26), and inability to conduct a physical exam to the degree required (40.0%, n=22) as somewhat of a challenge; conversely, a moderate proportion rated poor communication/ support from leadership (38.2%, n=21) as not a challenge.

Table 2 Summary of Survey Responses

Did you perceive patients incarcerated were more stressed overall during the COVID-19 outbreak?	
Yes	83.6% (n=46)
No	12.7% (n=7)
N/A	3.6% (n=2)
Did you have more suicides or suicide attempts during COVID-19 at your facility?	
Yes	30.9% (n=17)
No	50.9% (n=28)
N/A	12.7% (n=7)
Unknown	5.5% (n=3)
How did mental health care delivery change at your facility during COVID-19?	
Continued in person:	30.9% (n=17)
Reduced Services:	38.2% (n=21)
Hybrid:	36.4% (n=20)
In-person to tele:	18.2% (n=10)
Other	7.3% (n=4)
Did you continue to do groups during COVID-19?	
Yes:	23.6% (n=13)
No:	50.9% (n=28)
N/A:	25.5% (n=14)
How was managing psychiatric medications by tele video conferencing during COVID-19?	
Easy:	29.1% (n=16)
Moderate:	34.5% (n=19)
Difficult:	9.1% (n=5)
N/A:	27.3% (n=15)
Did the number of general medicine/mental health providers providing psychotropics increase significantly due to COVID-19?	
Yes:	10.9% (n=6)
No:	76.4% (n=42)
N/A	12.7% (n=7)
Please rate your belief on the potential of tele mental-health relative to in-person care:	
Lower quality than in-person with masks	47.3% (n=26)
Equivalent to in-person with masks	34.5% (n=19)
Higher than in-person with masks	14.5 (n=8)
N/A	3.6% (n=2)
Moving forward, do you see an increasing role for tele-delivery of mental health services?	
Yes:	80% (n=44)
No:	16.4% (n=9)
N/A:	3.6% (n=2)

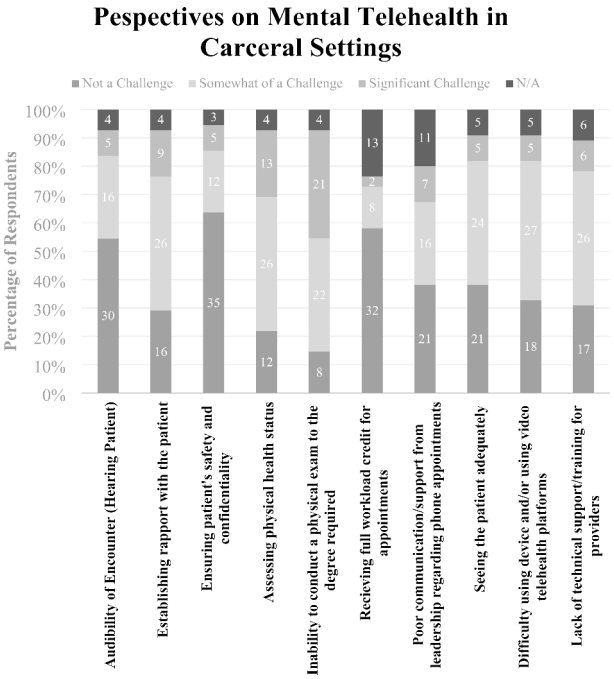

Fig. 1 Perspectives of mental telehealth in carceral settings

In the qualitative response section (Supplementary Material), perspectives of mental health and healthcare, specifically during COVID-19, included entering carceral settings in unsteady states, increased stress from delays in court processes, decreases in the mental health workforce, variability in telepsychiatry implementation, reduced groups, and stress secondary to lockdowns and repeated isolation. Qualitative responses on positive facets of mental telehealth were the ability to manage most mental health concerns, increase in access, routine outpatient visits, and the slight preference among patients for in-person counseling once COVID was under control. On the other hand, qualitative responses on negative facets of mental telehealth care related to logistic and technological barriers, insufficiency of therapeutic relationships, and the contributing role of a provider shortage.

Discussion

We surveyed a sample of carceral health clinicians on their perspectives on using mental telehealth services within carceral facilities during the COVID-19 pandemic. Respondents broadly agreed that mental telehealth services could serve as a stopgap amid infection prevention measures and resource-limited settings but may not be sufficient to replace in-person services completely. Understanding these clinician perspectives will help guide future mental health delivery through traditional and emerging models of carceral health care.

A slight majority of our cohort believed mental telehealth to be of poorer quality than in-person services. Even so, most respondents indicated telehealth modalities would serve a role in the future of carceral mental health due to prevailing financial and administrative pressures. This reflects an overall pessimism collected in our qualitative response section

surrounding the recruitment of providers, funding, and political will to improve carceral health paired with an optimistic resolve to do the best possible work despite difficult circumstances. Outside of carceral settings, patients have noted problems forming relationships over telehealth modalities, and inquiries into the feasibility of mental telehealth for rural carceral facilities noted that gaps in familiarity with facility procedures could impact the therapeutic relationship [9, 19]. Results from our preliminary study indicate that the carceral health setting is no different. However, based on our survey, provider availability is a more pressing challenge in the carceral environment. Respondents in our qualitative response section suggested that access to mental health providers is of greater urgency than the modality used.

The cohort we surveyed also reported that technical and bureaucratic barriers were among the most significant obstacles to providing effective and timely mental telehealth, much of which may not be within the scope of the provider's ability to address. Populations in carceral facilities are uniquely vulnerable to pandemics, necessitating innovative infection mitigation strategies and preventing further challenges when implementing telehealth modalities [8]. Infection prevention strategies may also exacerbate existing mental health conditions, which increases the complexity of cases clinicians are expected to manage virtually [20]. Ultimately, our cohort cited a lack of funding for appropriate staff, varying levels of technological competence across facilities, and poor patient clinical spaces as other barriers. These barriers to effective mental telehealth further compound existing difficulties with mental healthcare delivery in carceral facilities [21]. Correcting variability in technical equipment and standardizing staff practices on an inter-facility basis may be a necessary first step for carceral mental telehealth to succeed broadly.

Roughly 30% of our cohort reported that suicidal attempts and stress had increased among patients within their facilities. This increase was paired with the cessation of group mental health sessions in most facilities and a plurality of respondents who reported significant cutbacks in services at their respective facilities. Without more funding for staff and services, expanding mental telehealth could be an invaluable resource to allow patients with deteriorating mental health status more frequent contact with providers. Most of our respondents also reported no significant issues with the management of psychiatric medications over the telehealth modality, suggesting that an essential role for telehealth in the future may be to maintain stable patient populations and allow more time for in-person acute care.

Although our cohort identified multiple problems within mental telehealth delivery, there was near unanimous agreement that mental telehealth will be an enduring aspect of mental healthcare delivery. Our cohort cited financial constraints and understaffing as the most significant barriers to consistently delivering high-quality mental health care within the carceral system via telehealth and traditional modalities. Our qualitative responses broadly underscored the practical benefits of tele-mental health but highlighted the need for continued development.

Our study had several limitations. We distributed our survey to a heterogeneous sample that may not reflect all the experiences of front-line mental health workers during the COVID-19 pandemic. For example, some respondents were retired or in administrative roles. However, carceral health clinicians still retain considerable expertise on the logistics and challenges in carceral settings, if not necessarily providing frontline care. Further, there is the potential for responder and non-responder bias. For example, we lack data regarding the number of respondents that viewed the survey but did not complete it. Addition-

ally, the sample of n = 55 is small and limits external validity to carceral health clinicians broadly. Also, given the heterogeneity among the respondents, an additional limitation is posing behavioral health questions to providers of different specialties (e.g. querying non-psychiatrists opinions on managing psychiatric medications via telehealth.) However, our respondent cohort comprises primary care physicians (PCPs). PCP's lead psychiatric care in up to 1/3 of their patients, which may be higher in carceral settings, where general medical or custody staff may handle mental health conditions in the absence of mental healthcare professional [22, 23]. Finally, our survey is not a validated instrument; though, it was formulated with the expertise of clinicians with backgrounds in psychiatry, internal medicine, and leadership.

Conclusion

Our study parallels and expands upon existing literature on telepsychiatry and offers essential insight into clinician experience with mental telehealth in carceral settings. Our survey highlights the increased stress and mental health toll COVID-19 placed on legal system-involved populations and the shortage of resources, including providers, to meet the increased demand. Respondents viewed telepsychiatry as playing an important future role. However, they viewed the technical aspects of telepsychiatry and establishing rapport with patients as somewhat challenging, and a slight majority viewed it as overall inferior to in-person care with masks. Thus, addressing the mental health burden in carceral settings includes optimizing the delivery of telepsychiatry in conjunction with increasing resources on site. Future studies can utilize mixed methods to provide more information about longitudinal therapeutic outcomes and practical considerations for possible mental telehealth implementation in carceral settings.

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Declarations

Conflict Disclosures None.

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