

Barriers to access to psychiatric medications in Missouri county jails

Jessica K. Burval, PharmD, BCPP¹; Courtney A. Iuppa, PharmD, BCPP²; Carrie R. Kriz, MS³; Shelby E. Lang, PharmD, BCPP⁴; Leigh Anne Nelson, PharmD, BCPP⁵; Nicole A. Gramlich, PharmD, BCPP⁶; Ellie S. R. Elliott, PharmD, BCPP⁷; Roger W. Sommi, PharmD, BCCP, FCCP⁸

How to cite: Burval JK, Iuppa CA, Kriz CR, Lang SE, Nelson LA, Gramlich NA, Elliott ESR, Sommi RW. Barriers to access to psychiatric medications in Missouri county jails. *Ment Health Clin* [Internet]. 2023;13(5):200-6. DOI: 10.9740/mhc.2023.10.200.

Submitted for Publication: April 5, 2023; **Accepted for Publication:** June 12, 2023

Abstract

Introduction: Objectives of this study were to characterize barriers to receiving psychiatric medications for people who are incarcerated, to compare barriers before competency restoration to those after competency restoration, and to characterize psychiatric medication formularies.

Methods: A survey of county jails in Missouri was completed between October 2021 and February 2022. Survey questions were answered by medical department personnel, nurses, or a person responsible for medication oversight. Formularies were requested.

Results: Of 97 jails contacted, 51 completed the survey (53%). Most jails allowed patients to supply their own medications and reported they were “often” or “always” able to continue home medications. Inability to provide home medications was frequently attributed to cost. Notably, only 57% of jails were able to provide long-acting injectable antipsychotics (LAIA), 22% charged a fee for administration of medications, and 31% would not adjust medication times based on food requirements. No major differences existed precompetency and postcompetency for any question.

Discussion: Jail policies varied; thus, medication access for patients should be approached at the individual level. Potential areas to target to improve access are medication administration times, LAIA access, and removal of medication administration fees.

Keywords: barriers, psychiatric medication, jail, forensic

¹ Behavioral Health Clinical Pharmacy Specialist, Cleveland Clinic Marymount Hospital, Garfield Heights, Ohio; ² (Corresponding author) Clinical Pharmacy Manager and PGY-2 Residency Program Director, Missouri Department of Mental Health, Center for Behavioral Medicine, Kansas City, Missouri, courtney.iuppa@dmh.mo.gov; ³ Clinical Research Coordinator, University of Missouri-Kansas City School of Pharmacy, Kansas City, Missouri; ⁴ Clinical Pharmacist, Missouri Department of Mental Health, Center for Behavioral Medicine, Kansas City, Missouri; ⁵ Professor of Pharmacy Practice and Administration, University of Missouri-Kansas City School of Pharmacy, Kansas City, Missouri; ⁶ Clinical Pharmacy Manager, Missouri Department of Mental Health, Northwest Missouri Psychiatric Rehabilitation Center, St. Joseph, Missouri; ⁷ Director of Pharmacy, Missouri Department of Mental Health, Center for Behavioral Medicine, Kansas City, Missouri; Director of Pharmacy, Missouri Department of Mental Health, Northwest Missouri Psychiatric Rehabilitation Center, St. Joseph, Missouri; ⁸ Associate Dean and Professor of Pharmacy Practice and Psychiatry, University of Missouri-Kansas City School of Pharmacy, Kansas City, Missouri

Disclosures: This study received no financial support, and no authors have conflicts of interest to disclose.

Introduction

In 2021, local jails in the United States held 636 300 people according to the Bureau of Justice Statistics Annual Survey of Jails.¹ Within the jail population, 44% of people in 2011-2012 reported a history of being diagnosed with a “mental health problem” such as bipolar disorder, depression, schizophrenia, anxiety disorders, and others.² Estimates within correctional systems vary, with some reporting 17% to 30% of people experiencing psychiatric disorders and greater than 50% experiencing substance use disorders.³⁻⁵ Despite the right of those who are incarcerated to have access to health care,^{6,7} it has been documented that this does not always occur.^{8,9} Wilper et al⁸ found that of those on any prescription drugs at the time of incarceration, 26.3% of federal, 28.9% of state, and 41.8% of jail

incarcerated persons were not continued on that medication. Consequences for people with psychiatric disorders who have a lack of access to treatment while incarcerated include decompensation, disciplinary action from correctional staff, increased victimization from others, and placement in solitary confinement.¹⁰⁻¹² Furthermore, lack of medication access may increase the risk of individuals being found incompetent to stand trial.¹³ Competence to stand trial is a determination of an individual's "ability to participate meaningfully in legal proceedings."¹⁴ If one is deemed incompetent, the court may mandate competency restoration through "psychiatric treatment and education" at a psychiatric hospital or other mental health facility.¹⁴ With a shortage of beds and long wait lists for admission to such facilities, it is worth optimizing access to care for those who are incarcerated.¹³ In addition, access to appropriate medications is necessary so individuals restored to competency can maintain psychiatric stability upon return to jail.

Several studies have assessed the available resources and accessibility of treatment for incarcerated persons. Jacobs and Giordano⁹ surveyed individuals with psychiatric diagnoses and multiple instances of detainment to characterize psychiatric services in jails. They found medication management, psychosocial assessments, and crisis intervention were often lacking. They note that inaccessibility of medications or unnecessary medication adjustments occurred, which led to withdrawal or decompensation. They also found that incarcerated persons were often not fully assessed for psychiatric needs and did not have access to clinical staff despite the potential need for immediate crisis intervention. Scheyett et al¹⁰ interviewed jail administrators in North Carolina to compare screening, provision of mental health care, and discharge coordination. Of 80 jails, 15% had mental health staff and 48% had a community mental health agency that could send staff to the jail at varying frequencies. Of note, none of the community agencies would send a psychiatrist. Regarding access to medications, 86% allowed individuals to bring medications with them.

From a resources standpoint, a lack of dedicated funding for mental health services in jail is a major barrier for access.¹¹ There may only be enough funds to allow for a part-time medical provider, or there may not be one present at all.^{9,11} Where psychiatrists are available, they are often faced with a large caseload and limited collateral information on which to base treatment decisions.¹¹ In addition, as some psychiatric medications are costly, a limited formulary may result in individuals being unable to access their previous medication regimen while incarcerated.^{9,11,12,15}

Attempts to address barriers to accessing psychiatric care include incorporation of jail-based competency restoration programs and dedicated housing within correctional facilities for those with psychiatric illnesses.^{13,16,17} Despite the success seen with some approaches, costs often limit

feasibility. In addition, as others have noted, development of a competency restoration program within a jail should only be attempted after ensuring that mental health needs are being sufficiently addressed.¹⁶

This study sought to characterize barriers specifically related to psychiatric medication access in Missouri jails. The questions used in this study were developed based on the authors' experience working in a state psychiatric facility that focuses on competency restoration. Questions on long-acting injectable antipsychotics (LAIA) were included as they have been shown to prevent hospitalization and relapse in schizophrenia,^{18,19} to reduce hospitalizations in bipolar disorder,¹⁹ and to improve medication adherence and rate of medication discontinuation in both.²⁰ In addition, LAIA are frequently used at the state psychiatric facility during admission and on discharge back to jail after restoration of competency. Questions on medication administration were included to address concerns raised from previous incarcerated persons who reported the inability to adjust medication times while in jail despite taking medications that require food for absorption (eg, ziprasidone, lurasidone).^{21,22} Medication access and cost questions were based on reports indicating lack of access to certain medications and charges individuals were asked to pay in order to get their medications while in jail. Jails were asked about the ability of incarcerated persons to supply their own medications since the state psychiatric facility discharges them back to jail with access to 60 days of their medications. The authors wanted to establish the extent to which individuals would be able to use that medication supply upon discharge to jail.

In addition, this study sought to evaluate whether there was a difference in access for individuals precompetency and postcompetency. This issue was evaluated because of comments made to the authors from jail staff implying exceptions and differences in prescribing that were made to maintain competency in those returning to jail from the state psychiatric facility. Some examples of information provided by jail staff are that jails would ensure access to medications such as LAIAs for postcompetency patients and would continue medication regimens even if their typical approach was to use certain medications over others. It was anticipated that there would not be differences between the two populations, but based on those comments this evaluation was included. This study also sought to provide additional data on which psychiatric medications were accessible through the collection of formulary information.

Methods

A cross-sectional survey of county jails in Missouri was completed between October 1, 2021 and February 15, 2022. A list of jails and their contact information was compiled

TABLE 1: General survey questions (n = 51)

Question	Results, No. (%)
Are patients charged a fee for administration of medications?	
a. Never	38 (74)
b. Rarely	0 (0)
c. Sometimes	1 (2)
d. Often	1 (2)
e. Always	11 (22)
Does the facility have the capacity to provide medication that requires weekly blood monitoring (clozapine)?	
a. Yes	25 (49)
b. No	26 (51)
How frequently is someone available to draw blood for labs?	
a. Daily	20 (39)
b. Weekly	5 (10)
c. Every other week	1 (2)
d. Monthly	0 (0)
e. Other ^a	25 (49)
Does the current facility staff have the capacity to provide LAIAs?	
a. Yes	29 (57)
b. No	22 (43)
Does the facility currently participate in any pharmaceutical programs to receive free LAIA?	
a. Yes	0 (0)
b. No	51 (100)
Is there a monetary limit on how much can be spent on medications per patient?	
a. Yes	0 (0)
b. No	51 (100)
If there is a monetary limit per patient what is it?	
Is there a specific formulary?	
a. Yes	14 (28)
b. No	37 (72)

LAIA = long-acting injectable antipsychotic.

^aUnable to draw blood on-site.

using available Missouri Department of Mental Health resources and through an internet search of “Missouri county jails” and a search of jail names. Jails were contacted by telephone and informed that questions were related to medication administration and access, which was followed by a request to speak with someone knowledgeable on those procedures such as a nurse or a person responsible for medication oversight at that jail. If the person who was reached was unable to answer the questions, additional contact information was collected to ensure the survey was completed by someone who was knowledgeable regarding the medication administration policies at each facility. Following completion of the survey, a request was made for a copy of the jail medication formulary. Survey questions are listed in Tables 1 and 2 except for 4 open-ended questions that are addressed in the Results section. General questions (Table 1) were asked once for each jail. Precompetency and postcompetency questions (Table 2)

were asked twice, with respondents asked to answer for each population, respectively. Respondents were told that all questions were specifically related to psychiatric medications. Jails were included if they were within the state of Missouri and excluded if they did not respond to requests for survey completion after 3 attempts or did not complete the entire survey.

Study data were collected and managed using REDCap (Research Electronic Data Capture) electronic data capture tools.²³ REDCap is a secure, web-based application designed to support data capture for research studies. All data were exported and analyzed using Excel (Microsoft Corp) and SPSS 27 (IBM Corp). Data were analyzed using descriptive statistics.

This study was reviewed by the University of Missouri-Kansas City’s institutional review board and was determined to be exempt research.

TABLE 2: Precompetency and postcompetency questions (n = 51)

Question	Results, No. (%)	
	Precompetency	Postcompetency
Are patients able to refuse medications?		
a. Yes	51 (100)	51 (100)
b. No	0 (0)	0 (0)
Are patients subject to any adherence checks (ie, procedures to make sure medications have been taken)?		
a. Never	0 (0)	0 (0)
b. Rarely	0 (0)	0 (0)
c. Sometimes	0 (0)	0 (0)
d. Often	1 (2)	1 (2)
e. Always	50 (98)	50 (98)
Are patients able to supply their own medications (ie, provided by self, friends, family, etc.)?		
a. Yes	42 (82)	43 (84)
b. No	9 (18)	8 (16)
If a patient is not able to supply their medication, how often are they able to continue that same medication?		
a. Never	1 (2)	1 (2)
b. Rarely	2 (4)	2 (4)
c. Sometimes	3 (6)	1 (2)
d. Often	19 (37)	21 (41)
e. Always	26 (51)	26 (51)
Does the facility currently accept outside providers to come and provide LAIA?		
a. Yes	6 (12)	6 (12)
b. No	45 (88)	45 (88)
Do staff have any preference for LAIAs vs oral medications?		
a. Prefer LAIAs	1 (2)	1 (2)
b. Prefer oral	33 (65)	33 (65)
c. No specific preference	17 (33)	17 (33)
How many times daily are patients able to get medications?		
a. Once daily	0 (0)	0 (0)
b. Twice daily	23 (45)	23 (45)
c. 3 times daily	9 (18)	9 (18)
d. 4 times daily	12 (23)	12 (23)
e. More than 4 times daily	7 (14)	7 (14)
Can administration times be adjusted so patients can take medications with or without meals if needed?		
a. Never	16 (31)	16 (31)
b. Rarely	2 (4)	2 (4)
c. Sometimes	1 (2)	1 (2)
d. Often	2 (4)	2 (4)
e. Always	30 (59)	30 (59)
If patients have specific administration preferences (eg, prefer liquids, prefer to take medications at a certain time), how often are these requirements able to be accommodated?		
a. Never	16 (31)	16 (31)
b. Rarely	6 (12)	6 (12)
c. Sometimes	10 (20)	10 (20)
d. Often	16 (31)	15 (29)
e. Always	3 (6)	4 (8)

TABLE 2: Precompetency and postcompetency questions (n = 51) (continued)

Question	Results, No. (%)	
	Precompetency	Postcompetency
If there is a specific formulary, how often are patients able to access to nonformulary medications?		
a. Never	1 (7)	1 (7)
b. Rarely	0 (0)	0 (0)
c. Sometimes	4 (29)	3 (21)
d. Often	6 (43)	7 (50)
e. Always	3 (21)	3 (22)

LAIA = long-acting injectable antipsychotic.

Results

Of 97 county jails in Missouri that were contacted, 51 (53%) completed the survey. Results for closed-ended questions related to the general survey questions are listed in Table 1. Notably, 74% of jails reported never charging a fee for administration of medications, and 22% always charged a fee. There were 29 jails (57%) able to give LAIA and 25 (49%) able to do weekly laboratory tests. No jails participated in programs to receive LAIA at a free or reduced cost, and no jails had a monetary limit per patient.

Regarding the open-ended questions that were part of the general survey questions, jails were asked to identify any additional barriers to providing medications and if they had any other comments. Cost was frequently identified as a barrier to accessing medications (specifically LAIA). The identified cost concerns ranged from jails covering all medication charges to others requiring individuals to pay for prescription costs and additional administration fees per prescription. One jail reported incarcerated persons were not responsible for any costs related to medications. Two jails reported incarcerated persons would be responsible for all medication costs but would only be billed after they left the facility. One jail reported they generally charged for prescription medications but would not charge for psychiatric medications. Another reported that individuals were required to pay for over-the-counter (OTC) medications, but not prescriptions. Specific administration fees and prescription costs were minimally reported and varied widely. One jail charged \$10 per 30-day supply of each medication (with the facility covering any additional cost), which they did state limited their use of expensive medications. One charged a medication administration fee of \$1 per day per prescription, with individuals additionally responsible for the cost of the medication. One charged \$10 for a 120-day supply (\$5 for OTC) unless the individual supplied the medication. Another charged \$8 for any new prescription and \$4 for refills. Last, one charged \$5 for medication refills. Two jails reported charging monthly fees for anyone who needed medications. Two jails reported that incarcerated persons were required

to pay for medications up front; and if they did not pay, they would not get the medication. Cost of LAIA was noted to limit their use, with 3 jails stating they could only use patient-supplied LAIA, 2 jails stating they rarely used LAIA owing to cost, and 2 jails stating that they were unable to use them solely because of cost. Two jails noted that medication-related costs would often result in patients refusing their medications.

Unrelated to cost, other barriers were noted through the open-ended questions. One jail reported their prescriber would not start any new psychiatric medications. Two jails noted individuals who were not consistently taking psychiatric medications before being incarcerated would have to wait until they could be seen by a mental health provider before they would be prescribed medications. Another jail stated incarcerated persons had to prove they were on medications before coming to the facility to continue those medications. Last, one jail reported challenges in getting medication refills, which led to incarcerated persons not receiving their medications.

Results based on patients being precompetency versus postcompetency are listed in Table 2. There were few differences between the precompetency and postcompetency populations for all questions. All incarcerated persons at every jail were able to refuse medications and were always subject to adherence checks. At the time of the study, only 12% of jails accepted outside providers to give LAIA, and 65% preferred oral medications. The number of daily medication passes varied, but all jails had at least 2 passes daily. Administration times were always able to be adjusted for meals at 59% of jails, compared with 31% reporting they would never be able to make a mealtime adjustment.

There were differences in some precompetency and postcompetency questions. If there were differences, jails were asked an open-ended question regarding why those differences were present. The ability for individuals to supply their own medications was 82% precompetency compared with 84% postcompetency. One jail reported that they would only allow individuals to supply their own

medications if they were postcompetency restoration returning from a state facility. Another jail reported that if individuals did not supply their own medication, they would not get the medication. Whether jails had the ability to continue home medications was reported as “sometimes” for 6% and “often” for 37% precompetency compared with 2% and 41%, respectively, postcompetency. One jail reported that they would spend more money on continuing medications postcompetency to maintain competency. Last, access to nonformulary medications was reported as “sometimes” for 29% and “often” for 43% precompetency compared with 21% and 50% postcompetency, respectively. One jail reported that they put more priority into allowing nonformulary medications for postcompetency individuals but were not always able to.

When asked an open-ended question about medications that jails would not give, 12 of the 51 jails surveyed did not report specific restrictions on medications. In terms of restrictions, 11 jails reported that they would not provide any controlled medications, 16 jails would not provide benzodiazepines, and 20 jails would not provide opioids. Eleven jails reported that they preferred not to give controlled medications but would if needed. Less frequently, jails reported that they would not give quetiapine (6 jails), gabapentin (4 jails), bupropion (2 jails), trazodone (2 jails), muscle relaxants (2 jails), and hydroxyzine (1 jail). Characterization of jail formularies was a planned secondary outcome; however, only 14 jails reported having a formulary (28%), and the majority of those did not provide formulary information.

Discussion

The results of this survey support previous studies that have identified barriers preventing individuals from receiving their psychiatric medications while in jail. There was variability noted in accessibility to medications and policies regarding medication administration. While continuation of home medications and access to nonformulary medications were reported as “often” or “always” by the majority, many did note access on a case-by-case basis. Thus, even though the results of this survey show most jails would likely be able to make reasonable accommodations to allow individuals to access psychiatric medications, these results must be interpreted with this caveat in mind.

It was expected that there would be limitations in which medications jails would provide, with many of them not allowing access to controlled medications. When managing transitions of care, extra steps must be taken to confirm access to controlled medications or to transition someone off controlled medications prior to entering or returning to jail if possible. Another expected result was that most jails reported incarcerated persons were able to supply their own

medications. When individuals are discharged from the state psychiatric facility, they are sent with a supply of medications and access to refills, so it was anticipated that they would be able to use those supplies. It was notable that not all jails would allow this, as not all jails allowed individuals to supply their own medications. As expected, there were few differences precompetency and postcompetency for any question. It was reassuring to note no trends in treating postcompetency incarcerated persons differently, even in being more accommodating of medication needs postcompetency restoration.

There were results not aligned with what was expected. Most jails preferred oral medications. As previously stated, LAIA are frequently used in this population as they improve adherence and reduce both relapse and rehospitalization rates. Despite these potential benefits, jails noted that oral medication was preferred, and many stated this was because of cost and logistics of administering LAIA. For jails without medical staff on-site, administering an LAIA would require transportation to a clinic or hospital. In addition, based on concerns from previously incarcerated persons, it was assumed that there would be more problems in adjusting medication times based on food requirements. While more than half of jails would be able to accommodate mealtime adjustments, 31% would never be able to adjust administration times based on food. The ability to administer with or without food would be an important consideration when choosing which medication to use to restore competency. Last, the number of jails that always charged a fee for administration of medications was higher than anticipated at 22%. Incarcerated persons often do not have a source of income and are also ineligible for Medicaid, so it was not expected to see so many jails with administration fees. Charging for prescriptions or additional administration fees would be a significant barrier to medication accessibility.

This study is not without limitations. It was a cross-sectional survey of a single point in time. There may be limited generalizability to jails in other states, or even all jails in Missouri, given the variability and the survey response rate. This study was designed to identify jail policy and not actual jail practices. It is possible that jails reported being able to continue home medications or to provide access to nonformulary medications without this actually occurring. The study was also not designed to incorporate exceptions and decisional situations into data analysis, which should be considered when interpreting the results. Furthermore, survey respondents were staff at the jails as opposed to those prescribing medications, which could have biased reported information regarding access to certain medications and the ability to continue previously prescribed medications. Last, the second objective regarding formulary characterization was unable to be completed

given the few jails with formularies and the inability of many to provide their formulary.

The specific barriers varied across the population, which indicates that there is not a single answer or intervention that could universally improve medication access for incarcerated persons in Missouri. As noted above, most jails would be able to make reasonable accommodations for psychiatric medications; however, in some counties there are limitations in using all medications. Some potential strategies and possible state level policy changes for improving access to psychiatric medications are to remove medication administration fees, improve the ability of jails to adjust medication times based on meals, improve access to LAIA (both through cost and logistics), and allow individuals to supply their own medications (especially if the jail is unable to provide them).

Given the variability in policies, at this time medication access for people transitioning in and out of jail should be approached at the individual level. This is particularly important for those on LAIA and medications with high cost or specific administration instructions. Although some possible areas to target to improve access have been identified through this study, additional study of this variability among jails could provide additional insights into developing strategies to improve overall access to medications.

References

1. Zeng Z. Jail inmates in 2021 – statistical tables. Bureau of Justice Statistics [Internet]. 2022 Dec [cited 2023 Feb 26]. Available from: <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/jj21st.pdf>
2. Bronson J, Berzofsky M. Indicators of mental health problems reported by prisoners and jail inmates, 2011-12. Bureau of Justice Statistics [Internet]. 2017 Jun [cited 2023 Feb 26]. Available from: <https://bjs.ojp.gov/content/pub/pdf/imhrpji1112.pdf>
3. Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. Prevalence of serious mental illness among jail inmates. *Psychiatric Serv*. 2009;60(6):761-5. DOI: [10.1176/ps.2009.60.6.761](https://doi.org/10.1176/ps.2009.60.6.761).
4. Prins SJ. Prevalence of mental illnesses in US state prisons: a systematic review. *Psychiatr Serv*. 2014;65(7):862-72. DOI: [10.1176/appi.ps.201300166](https://doi.org/10.1176/appi.ps.201300166).
5. Bronson J, Stroop J, Zimmer S, Berzofsky M. Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009. Bureau of Justice Statistics [Internet]. 2017 Jun [cited 2023 Feb 26]. Available from: <https://bjs.ojp.gov/content/pub/pdf/dudaspi0709.pdf>
6. *Bell v Wolfish*, 441 US 520 (1979).
7. *Bowring v Godwin*, 551 F2d 44 (4th Cir 1977).
8. Wilper AP, Woolhandler S, Boyd JW, Lasser KE, McCormick D, Bor DH, et al. The health and health care of US prisoners: results of a nationwide survey. *Am J Public Health*. 2009;99(4):666-72. DOI: [10.2105/AJPH.2008.144279](https://doi.org/10.2105/AJPH.2008.144279).
9. Jacobs LA, Giordano SNJ. “It’s not like therapy”: patient-inmate perspectives on jail psychiatric services. *Adm Policy Ment Health*. 2018;45(2):265-75. DOI: [10.1007/s10488-017-0821-2](https://doi.org/10.1007/s10488-017-0821-2).
10. Scheyett A, Vaughn J, Taylor MF. Screening and access to services for individuals with serious mental illnesses in jails. *Community Ment Health J*. 2009;45(6):439-46. DOI: [10.1007/s10597-009-9204-9](https://doi.org/10.1007/s10597-009-9204-9).
11. Kolodziejczak O, Sinclair SJ. Barriers and facilitators to effective mental health care in correctional settings. *J Correct Health Care*. 2018;24(3):253-63. DOI: [10.1177/1078345818781566](https://doi.org/10.1177/1078345818781566).
12. Tamburello A, Metzner J, Ferguson E, Champion M, Ford E, Glancy G, et al. The American Academy of Psychiatry and the Law practice resource for prescribing in corrections. *J Am Acad Psychiatry Law*. 2018;46(2):242-43. DOI: [10.29158/JAAPL.003762-18](https://doi.org/10.29158/JAAPL.003762-18).
13. Ash P, Roberts VC, Egan GJ, Coffman KL, Schwenke TJ, Bailey K. A jail-based competency restoration unit as a component of a continuum of restoration services. *J Am Acad Psychiatry Law*. 2020;48(1):43-51. DOI: [10.29158/JAAPL.003893-20](https://doi.org/10.29158/JAAPL.003893-20).
14. Wall BW, Ash P, Keram E, Pinals DA, Thompson CR. AAPL practice resource for the forensic psychiatric evaluation of competence to stand trial. *J Am Acad Psychiatry Law*. 2018;46(3):S4-79. DOI: [10.29158/JAAPL.003778-18](https://doi.org/10.29158/JAAPL.003778-18).
15. Morris NP, Hirschtritt ME, Tamburello AC. Drug formularies in correctional settings. *J Am Acad Psychiatry Law*. 2020;48(1):2-6. DOI: [10.29158/JAAPL.003907-20](https://doi.org/10.29158/JAAPL.003907-20).
16. Felthous AR, Bloom JD. Jail-based competency restoration. *J Am Acad Psychiatry Law*. 2018;46(3):364-72. DOI: [10.29158/JAAPL.003772-18](https://doi.org/10.29158/JAAPL.003772-18).
17. Lamb HR, Weinberger LE, Marsh JS, Gross BH. Treatment prospects for persons with severe mental illness in an urban county jail. *Psychiatr Serv*. 2007;58(6):782-86. DOI: [10.1176/ps.2007.58.6.782](https://doi.org/10.1176/ps.2007.58.6.782).
18. Kishimoto T, Hagi K, Kurokawa S, Kane JM, Correll CU. Long-acting injectable versus oral antipsychotics for the maintenance treatment of schizophrenia: a systematic review and comparative meta-analysis of randomised, cohort, and pre-post studies. *Lancet Psychiatry*. 2021;8(5):387-404. DOI: [10.1016/S2215-0366\(21\)00039-0](https://doi.org/10.1016/S2215-0366(21)00039-0).
19. Bedggood M, Walton S, Bedggood M. Psychiatric hospitalisation before and after commencing long-acting injectable antipsychotic medication: a mirror-image study. *N Z Med J*. 2022;135(1560):37-47. PMID: [35999797](https://pubmed.ncbi.nlm.nih.gov/35999797/)
20. Greene M, Yan T, Chang E, Hartry A, Touya M, Broder MS. Medication adherence and discontinuation of long-acting injectable versus oral antipsychotics in patients with schizophrenia or bipolar disorder. *J Med Econ*. 2018;21(2):127-134. DOI: [10.1080/13696998.2017.1379412](https://doi.org/10.1080/13696998.2017.1379412).
21. Gandelman K, Alderman JA, Glue P, Lombardo I, LaBadie RR, Versavel M, et al. The impact of calories and fat content of meals on oral ziprasidone absorption. *J Clin Psychiatry*. 2008;70(1):58-62. DOI: [10.4088/jcp.08m04104](https://doi.org/10.4088/jcp.08m04104).
22. Preskorn S, Ereshefsky L, Chiu Y-Y, Poola N, Loebel A. Effect of food on the pharmacokinetics of lurasidone: results of two randomized, open-label, crossover studies. *Hum Psychopharmacol Clin Exp*. 2013;28(5):495-505. DOI: [10.1002/hup.2338](https://doi.org/10.1002/hup.2338).
23. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde JG. Research electronic data capture (REDCap)—a metadata-driven methodology and workflow process for providing translational research informatics support. *J Biomed Informatics*. 2009;42(2):377-81. DOI: [10.1016/j.jbi.2008.08.010](https://doi.org/10.1016/j.jbi.2008.08.010).