

A Team Approach to Correctional Psychiatry

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Abstract

Psychiatrists working in corrections are often working in geographical and professional isolation. This can contribute to a range of problems that include psychological burnout, overprescribing, and inability to resolve ethics dilemmas. We discuss staffing a correctional psychiatric unit with the team of psychiatrists from a university forensic psychiatric division. We then describe how this approach may alleviate or prevent the unwanted sequelae noted above.

Keywords: corrections; psychiatry; team; wellness

Introduction

Recently, the consulting psychiatrist of a treatment center at a maximum-secure and a medium-secure institution went on a career break, and four psychiatrists from an academic institution in Canada were appointed to fill the vacated role. Each of these psychiatrists will work one day a week, covering four days a week in total (one day less than the coverage provided by the previous psychiatrist). In this paper, we discuss the advantages and disadvantages of the new arrangement over the previous one, taking into consideration the challenges of working in a correctional environment, including professional isolation, patient demands, and sometimes unrealistic expectations from others. The center is an accredited psychiatric facility specifically designated for the treatment of patients incarcerated in the correctional system. Patients are referred from any of the other institutions on the basis that they require intensive mental health services. The admission criteria include the presence of the following:

- Major Mental Disorder, Neurological Disorder, Or Cognitive Impairment
- Personality Disorder
- Sexual Paraphilia (In Certain Circumstances)
- Significant Risk To Self Or Others
- Functional Impairment

Patient motivation and ability to engage in treatment is another important consideration. Patients may be admitted voluntarily or under the appropriate section of the Mental Health Act, under which the center is a recognized psychiatric facility. Although it is located on one government property, the center is split across two institutions: a maximum-security institution and a medium-security institution. The maximum-security site has a capacity of 90 incarcerated individuals, including six observation cells for enhanced monitoring of patients at increased risk for suicide or self-injury. The medium-security institution has a capacity of 36 beds. Both sites are staffed by multidisciplinary teams and operational staff with provision for psychiatric on-call coverage outside of working hours.

Team Approach

As early as 1964, Boslow described a team approach in a psychiatrically oriented correctional institution in the US. This institution, the famous Patuxant, was created in response to legislation in the state of Maryland that imposed on psychiatry and its allied professions the responsibility of treating and rehabilitating a large group of people who were defined by law as “defective delinquent[s]” (Boslow 1964, p. 37). The paper focuses on how the team, as directed by statute by a psychiatrist, worked together in the situation. Regehr and Glancy (2021) also describe an interprofessional team’s functioning in the delivery of mental health services. They note that the team works when two or more professions interact to improve the effectiveness and quality of patient care. The

authors describe challenges that team members encountered working together, including role blurring, conflict from different and contradictory professional values, and power differentials. The concept of an interdisciplinary team approach was established and developed along with mental health services in general. Bronstein and Abramson (2017) designate a framework for successful teamwork that includes meeting to determine common goals; setting contract terms of the current collaboration (written or unwritten); establishing team leadership; monitoring and refining team policies and procedures; and establishing methods for conflict resolution. Appelbaum *et al.* (2001) discuss the integration of security staff into the treatment team. They argue that correctional officers are the eyes and ears of the mental health team and should be included in treatment planning and monitoring. Psychologists have also long been part of the correctional team, working alongside psychiatrists. They can provide specialist assessment and treatment as well as valuable collaborative expertise (Dumont *et al.*, 2020). We did not find literature discussing teams of psychiatrists specifically in correctional institutions. Interdisciplinary teams are described as helpful for correctional outpatient teams (Roskes *et al.*, 2001). Peer support groups have been described for teams of general practitioners working within a practice, and it has been suggested that they improve patient care as well as the health of the practitioners (Howell & Wilson, 2004). Quinn *et al.* (2009) suggested that multidisciplinary in-hospital teams improve patient outcomes, and peer support has been shown to be useful in enhancing writing production in small groups of physicians.

Isolation And Lack of Support

It is not uncommon for correctional psychiatrists to be isolated geographically, professionally, and personally. Long-term correctional facilities or prisons tend to be located outside urban centers. Psychiatrists who work in these institutions are often under contract and may have to drive long distances to get to the institutions and work long hours with enormous caseloads. There are several different funding models across North America, including in Canada (Trestman, 2015). Most models involve contract arrangements, including outside vendor models, which might include global or split contracting. In Canada there is a hybrid model for the provision of psychiatric services that involves a mix of contract arrangements and collaborations with academic institutions (e.g., Queen's University, University of Saskatchewan, Philippe-Pinel National Institute of Forensic Psychiatry, University of British Columbia) (Cameron *et al.*, 2021). In practice, the delivery of psychiatric services often ends up in the hands of sole practitioners who work across multiple institutions. Because the geographical locations of these institutions are often far from urban centers or university medical schools, psychiatrists are often professionally isolated. There have been various approaches to the housing and treatment of individuals with mental disorders across jails and prisons (Dvoskin & Brown, 2015). Dedicated housing can concentrate mental health services in a specific part of the institution. This model keeps people with mental disorders away from those without mental illness, which enhances the security of those with mental illness, as well as the totality of the system. Gage (2015) notes that a psychiatrist working in this environment must come to terms with the relevant "alien reality" in that setting to be satisfied with the work and clinically effective. He goes on to say that many clinicians in this area become overwhelmed and professional solitude is a challenge. Geographical isolation coupled with relatively low staffing models means the psychiatrist practices in relative isolation compared to most hospital or group practice models. There are unlikely to be colleagues available for

discussions, collegiality, peer support, or consultations. Owing to differences in professional perspectives, it may be difficult for the psychiatrist to turn to other members of the multidisciplinary team for support and mentorship. Notably, correctional psychiatrists are not necessarily forensic psychiatrists (Glancy, 2015). Although some have posited that this should be the case, the reality is that forensic psychiatrists are not always available to work in correctional institutions, especially when these institutions are geographically remote. Traditionally, correctional psychiatrists have not belonged to organizations of general psychiatrists or forensic psychiatrists, although some commentators regard correctional psychiatry as a subspecialty of forensic psychiatry (Cameron *et al.*, 2021). This lack of belonging compounds the sense of professional isolation and might also contribute to a failure to raise standards of care.

Constant Patient Demands

Several commentators have opined on the types of stresses correctional psychiatrists cope with in the short and long term (American Psychiatric Association 2015). Stresses include lack of decent office space, dealing with the prison culture, safety concerns, and such inefficiencies as patient access barriers (Gage, 2015). In addition to the high caseload, Gage notes the problem of limited access to consultation, which might otherwise be easily available, for instance, in a psychiatric hospital setting. In addition to systemic pressures, there are difficulties in dealing with high volumes of patients with a high prevalence of substance-related and personality disorders (Fazel & Danesh, 2002). Even in the presence of serious mental disorders, comorbidity with substance use disorder and personality disorder is so common as to be the norm. Consequently, prescribing in corrections has unique challenges and can be the source of considerable stress (Tamburello *et al.*, 2020). Illegal or street drugs are difficult, though not impossible, to obtain in correctional facilities; thus, it is not uncommon for people to attempt to obtain replacements from prescribers. A variety of drugs may fill the bill, but the most common are benzodiazepines, psychostimulants, and more recently, derivatives of THC, such as Nabilone (Tamburello, 2015). Efforts to obtain these medications can involve malingering (Knoll, 2015), threatening violence, threatening legal action, or threatening to report the psychiatrist to their medical licensing body. Many patients come up with ingenious explanations, including the death or retirement of a fictitious prescribing physician; previously obtaining the medications from a relative, such as their mother; previously obtaining the medication in a foreign country, claiming no other medications worked; and other elaborate narratives. Dealing with these pressures is exhausting and wearing, thereby contributing to physician burnout and lack of efficacy. As noted above, comorbidity in patients in corrections is the norm rather than the exception, resulting in patients who are exceptionally difficult to serve. It is not uncommon for a psychiatrist to have to deal with acute psychotic symptomatology overlaid with significant personality attributes, which can make diagnosis and treatment both difficult and hazardous. The overlay of personality disorder on acute mental illness is particularly stressful for the treatment team. In the hospital setting, this is often dealt with by consulting with colleagues of various disciplines, who can provide ideas about treatment avenues and implicitly offer support for the psychiatrist. In isolated correctional centers, it can be challenging to obtain consultation from peers or experts in a particular field. Therefore, the clinical load falls on the psychiatrist, who has to endure most of the stresses involved. In hospital settings, corridor consultations and informal discussions with colleagues can provide some of these functions, but this

is often impossible in remote correctional facilities. Symptoms of burnout can lead to decreasing quality of care, as well as dissatisfaction from both physicians and patients (Quinn *et al.*, 2009). A psychiatrist under undue stress will likely lose some efficacy. This can lead to undesirable or inappropriate practices, with adverse health and security consequences. For example, a strong and well-supported physician can resist the pressure to prescribe inappropriate controlled or excessive doses of medications; however, this resistance can be broken down for a psychiatrist who is experiencing burnout. Once the psychiatrist starts to give in, the floodgates can open for requests from other incarcerated individuals, which are increasingly hard to deny. This can lead to inappropriate prescribing and eventual harm to patients, as well as threatening the safety and security of the institution.

Difficult-To-Resist, Unrealistic Management Demands

In addition to their obligation to the patient, psychiatrists in corrections are also obliged to support the safety and security of the institution (Glancy & Simpson, 2018). This compounds the stress felt by the correctional psychiatrist, who often wrestles with these ethical dilemmas daily. The management structure in correctional mental health is somewhat different from that of a hospital or community health service, whose exclusive goal is health care delivery. In the correctional situation, management is often security rather than health care personnel. The management mode and goals may differ entirely from a psychiatrist's experience in a health care setting. Often, management goals are not realistic, sensitive to, or within the grasp or mandate of practicing psychiatrists. Policies and procedures can also impact treatment delivery. Planning the delivery of health, such as seeing a patient at predefined intervals (e.g., every day, every five days, every 15 days), which may not be clinically indicated, contributes to burnout. Medical defence organizations that represent psychiatrists working in hospital or community settings may be unfamiliar with the additional burden of correctional psychiatry and thus unwilling to support and represent them. To address some of these challenges, the Correctional Service of Canada (CSC) has progressively shifted towards independent health governance by relying on Accreditation Canada for external accreditation of health services and delineation of budget lines, to allow health services managers to determine health care staffing and policies (Cameron *et al.*, 2021).

Knowledge and competence

In most hospital settings, psychiatrists benefit from both formal and informal continuing medical education. Informal discussions, reading other physicians' charting, and formal continuing education are the norm in a hospital setting. These attributes would be most unusual, however, in a correctional setting. Isolated psychiatrists are therefore at risk of not benefiting from continuing medical education, which could result in a decline in clinical competence. As well, older physicians benefit from practicing in close collaboration with younger physicians, who have greater knowledge of new ideas and technologies. In some respects, there is pooled knowledge in a group of hospital-based psychiatrists, which may be shared among group members through various formal and informal means. This is not readily available to geographically isolated correctional psychiatrists, potentially leading to psychiatrists using outdated methods for years because they do not have the impetus to change. Based on our experience, an alternative scenario is when a correctional psychiatrist experiments with innovative therapies they have read about but are not actually done in a hospital setting. These practices, such as polypharmacy, are sometimes inappropriate in a correctional

setting. In both scenarios, the correctional psychiatrists do not have peers available with whom to compare their practice, nor are others around who can ensure they are practicing with the same standards.

Referring Patients to A New Provider

Issues of countertransference are particularly pertinent in a correctional setting. This is partly attributable to the high rate of comorbidity of all disorders with concomitant personality and substance use disorders. In hospital settings, countertransference can be dealt with by referring the patient to another physician, or at least by consultation with other physicians. This may not, however, be possible in an isolated correctional setting, resulting in the psychiatrist continuing to treat the patient despite being unable to resolve countertransference issues. In the long term, the psychiatrist may feel they are serving a life sentence with the patient! The situation is particularly stark if the patient has threatened or even physically attacked the psychiatrist. It is difficult to rebuild a therapeutic rapport in these circumstances. Even short term, issues of countertransference can lead to less effective treatment and dissatisfaction of both the psychiatrist and their patient. Isolated correctional psychiatrists have few avenues available for resolving this. Other possible scenarios include if the psychiatrist over-identifies with their patient, resulting in over- or inappropriate prescribing and treatment patterns, or if they begin to fear or dislike their patient, which can have the same results. This is bound to raise ethical dilemmas with respect to the basic principles of beneficence and nonmaleficence.

Advantages of the New System

Several correctional institutions in this area are built in the same geographic region to facilitate transfers among various levels of security. The government had previously signed a memorandum of understanding (MoU) with a university's psychiatry department to provide mental health support to people who were federally sentenced, as the university was geographically close to a conglomeration of institutions. This MoU only funded two psychiatrists, however, and could not provide enough staffing for all institutions in the area. In 2021, the director of the treatment center addressed the shortage by contracting members of the Division of Forensic Psychiatry and Department of Psychiatry at the University of Toronto to provide services to the center. Each of the four contracted psychiatrists spends one day a week at the center, some of which is done virtually using a secure virtual platform. All four spend the rest of the week completing duties related to the Division of Forensic Psychiatry at the University of Toronto. They may continue to live and work in the university setting, attend the usual number of meetings in that setting, and stay in regular contact with their colleagues. They attend regular interdisciplinary team meetings at the center and have set up a monthly meeting to discuss a variety of issues arising from their work there. As a result of this arrangement, the psychiatrists remain in their university setting and are less likely to experience geographical or personal isolation. They maintain close collegial relationships with their University of Toronto peers, attend meetings and rounds in a similar fashion, and have access to continuing medical education, as previously experienced. The psychiatrists interact with each other frequently and often debrief with the group at the end of the day. This helps each of them reflect on the day's work and seek input from their peer group. It also enables them to share any relevant information with the person who will be in attendance the next day. The team convenes monthly to consider any issues that arise and together meet with the regional director to discuss issues of policy and practice. Quinn *et al.* (2009) refer to "communities of practice," in which

colleagues support one another; we believe such communities aid in preventing physician burnout. Regarding the acute and most worrying patients in the center, the psychiatrist working the next day routinely has an opportunity to review the case. This informal consultation mechanism reassures the psychiatrist that their work is attaining the standard of care and they are not missing any details. The arrangement has the significant benefit of sharing the emotional load implicit in dealing with severely ill patients. It is not unusual for two or more of the psychiatrists to informally communicate about forward planning for some of the most difficult patients. The team arrangement further allows another psychiatrist(s) to review orders or prescriptions. If it is felt the medication prescribed does not meet the standard of care, the psychiatrists are comfortable with and able to discuss their concerns with one another and rectify any errors. Each also has a varying degree of familiarity with the provincial Mental Health Act, making it easy for them to consult one another to ensure proper legal procedures are followed.

Countertransference

Issues of countertransference are significant and central to work in correctional psychiatry. Having colleagues who are easily available, familiar with the situation, and know the specific patient(s) can help in handling the issue; discussing a situation with a colleague can be invaluable. In other situations (e.g., where a patient has made serious threats or attempted assault), it may be prudent to refer the patient to a colleague who can start afresh and build a new relationship with the patient; with four psychiatrists on the team, options are available. In some scenarios, transference and countertransference can be diluted by rotating the patient through different members of the team. This has the additional effect of reaffirming the psychiatrist's decisions, which can reassure the patient and defuse difficult situations. A patient's lack of progress can sometimes be related to countertransference, and referral or consultation can assist in handling this issue. This referral can reassure the psychiatrist and patient, who may be frustrated with each other and the situation.

Coverage During Absences

Because all four of the psychiatrists on the team are familiar with the patients and procedures, coverage for vacation and study leave is readily available. This isn't the case for single psychiatrists working in isolation, who return from leave and are often overwhelmed with excessively long clinics and accumulated administrative tasks. This avalanche of work can quickly diminish the benefits from leave. The team approach can help alleviate this problem.

Burnout

Features of physician burnout include emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment (Wilkie *et al.*, 2022). Although there is no literature to support this directly, we hypothesize that many psychiatrists working in the conditions described above would experience burnout syndrome, because many of the factors inherent in an isolated prison setting are likely to contribute to burnout. Burnout can lead psychiatrists to believe they cannot be helpful to their patients, which produces irritability in the face of multiple requests for help. Not uncommonly, overinvolvement can turn into exhaustion and cynicism, leading the psychiatrist to become ineffective in their position. We argue that adopting the team approach illustrated above prevents many of the risk factors for burnout. Certainly, the job of a correctional psychiatrist may still be somewhat stressful, but the team approach can dilute many of these sources of stress. In addition, it

provides a group of peers who can notice burnout and advise on appropriate sources of intervention. Having a team means colleagues can relieve a psychiatrist of some of their workload, including administrative duties, so that the affected member can attend to their own needs and seek appropriate help and counsel to alleviate these troublesome features.

Disadvantages of the New System

It would be trite to say this approach completely alleviates all stresses or concerns about working in corrections. There are still stresses, many of which are common to any other physician, such as the burden of electronic medical records. The workload remains intense despite the support of the physician community and an excellent multidisciplinary team. This arrangement might affect continuity of care, though we have no evidence thus far that this is the case. One challenging issue to resolve is when patients appeal findings of incapacity to consent to treatment or involuntary commitment to the provincial review board, it may be difficult to arrange for a specific psychiatrist to be on rotation on a given day. Thus far, the psychiatrists address this issue by taking time out of their other duties to attend the board. They are still searching for an alternative.

Conclusions

A correctional center recently took a new approach to providing psychiatric care to their two centers and hired four forensic psychiatrists from a university center to offer one day of care each week. In this paper, we have identified many features of correctional psychiatrists' experiences, including assimilating into the alien culture of correctional institutions. Correctional psychiatry demands an attenuation of the ethics basis of the practice in that correctional psychiatrists serve two ethics masters in their dual responsibility to the patient and to the security of the institution. The institution also has a different management structure and significant oversight by nonmedical structures. It is well known that correctional psychiatrists practice in conditions of both professional and geographical isolation, resulting in a significant lack of support. This can give rise to increasing levels of stress and burnout, culminating in a lack of efficacy and, thus, a reduced standard of care for patients. In the new team approach, the four psychiatrists frequently communicate, both formally and informally, and provide a community of support. They remain well connected within the university system and practice in that setting for most of the week. Each psychiatrist has their own level of knowledge and experience, which they readily share with other members of the team as needed. In the naturalistic setting of continuity of care, the psychiatrists routinely provide formal and informal daily consultation to one another and may cover for each other for vacations or when a psychiatrist is participating in continuing medical education. This approach reduces professional and geographical isolation and, we posit, is one factor that can help prevent burnout. Correctional psychiatry may still be intense and stressful, but the team approach can be used to alleviate some of these stressors and the resulting problems associated with correctional psychiatry by preventing burnout and increasing the standard of care. In this way, the team approach will produce more effective patient care, which must be the ultimate goal of any health care system.

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