A Silent Man from a Voiceless Population

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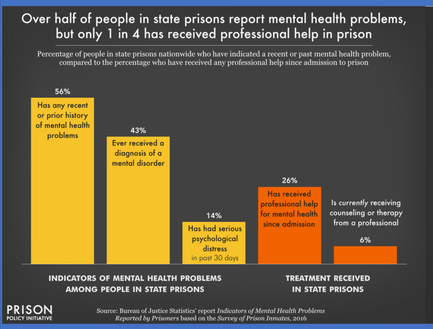
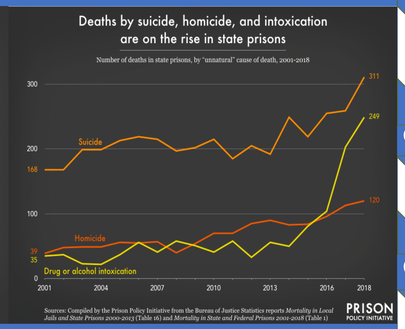
Background

- Incarcerated individuals with severe mental illness generally receive insufficient treatment.
- Suicide rates among incarcerated individuals with mental illness are six times higher than in the general population (Galanek et al, 2014)
- Though legislation requires people in custody to receive adequate health care, standards for "adequate care" are largely driven by litigation (e.g., Estelle v. Gamble) rather than by correctional facilities' attempting to develop best practices (Canada et al, 2022).





- The question of whether a mentally ill offender should be treated in a psychiatric hospital or in prison remains politically controversial, and access is limited. However, individuals with psychotic illness therefore require removal to hospital treatment because of life-threatening self-harm, risk of violence, or victimization of other prisoners (Konrad et al, 2012).
- Incarcerated individuals thus face either long waitlists at local psychiatric hospitals and/or repeated hospitalizations for symptoms that could have been avoided if there were stable, consistent, and adequate mental health care available in prisons.
- Deinstitutionalization and reduction in the number of psychiatric inpatient beds have contributed to this mental health crisis in the U.S. criminal justice system (Gao et al, 2021)

Case

- This case shows how delayed identification and mismanagement of a mental health crisis greatly impeded medical and psychiatric care of a prisoner with catatonic schizophrenia, highlighting the flaws in the health care system for incarcerated individuals.

Clinical Course

9/17 A 36 yo male receiving apriprazole 20 mg daily and valproic acid 750 mg BID for schizophrenia is admitted from prison to OSH for confusion, stiffness, and 27-lb weight loss from a five-week "hunger strike." Two weeks PTA he had been moved to a secure psych area due to "acting bizarre." CT head shows subarachnoid hemorrhage; valproate levels are subtherapeutic.

9/20 OSH psychiatric consultant does not deem patient catatonic and recommends Haldol 10 mg IM qd. Per correctional facility medical director, patient's mother is HCPOA and next of kin, and consent obtained for MRI was obtained from her.

9/25 Psychiatric re-evaluation finds possible catatonia. After Ativan 2 mg TID is begun, patient becomes AAOx3 and agreeable to care. The hospital unsuccessfully attempts to contact the prison medical director for permission to update pt's mother after having been instructed not to call her.

9/27 Psychiatry finds the patient no longer catatonic but still lacking decision-making capacity and requests that corrections officials designate a surrogate (being unable to inform his mother who is still in contact). Despite decompensating again, the patient is discharged back to prison.

10/5 He is sent to a different OSH ED for decreased PO intake and concern for encephalopathy. Patient says, "My mind is freaked." Psychiatry consultant recommends inpatient psychiatric hospitalization but is unable to contact prison medical director.

10/6 Patient is admitted, and apiprazole is changed to olanzapine. Patient's condition again stabilizes with benzodiazepines. On 10/17, he is returned to prison, where benzodiazepines are not continued.

10/28 After 10 days in the Correctional Infirmary for a repeated decompensation, he is returned to UMMC ED for poor PO intake. He again improves with benzodiazepines. Correctional infirmary acknowledges repeated admissions for inadequately controlled mental illness but has not continued psychiatric treatments or medications begun in hospitals. The status of surrogate decision-making and emergency contact remain unresolved and inconsistent.

Discussion

Substandard care within prison, inaccurate attribution of symptoms, and corrections' interference with and failure to continue appropriate care provided at outside hospitals greatly worsened this patient's condition. Accreditation of prison health care is optional and is poorly regulated (Canada et al, 2022); therefore, both understanding of and ability to continue hospitals' care plans may be lacking, as in our case. Since correctional officers are essentially gatekeepers to care, prisoners with impaired communication or capacity are at particular risk. An account by an incarcerated individual highlights this:

"…you gotta fill out the sick slip and give it to the guard maybe and maybe he'll put in the sick box, and they get it later or whenever they decide to pick it up" (Canada et al, 2022)

Our patient endured five weeks of what was deemed a "hunger strike," as well as a subarachnoid hemorrhage, and a two week period in correctional psychiatric unit addressed neither condition properly. A study examining an accountability model implemented between correctional officers and incarcerated individuals demonstrates the importance of this therapeutic alliance:

"If they really don't know you, or think you're playin' [manipulating], they'll tell you to write a kite. If the officer likes you, and you're for real with them [officers], they'll do you a favor, they'll help you. There's trust there. (Galanek et al, 2014)

Currently, correctional health care providers, facilities, and staff are unprepared for complex, severe medical and psychiatric illnesses. Without adequate regulation or standards for expertise and treatment facilities, there is no mechanism to ensure quality care psychiatric care for the incarcerated SMI population. Barring regulatory changes, the burden falls to outside hospitals that treat prisoners to advocate for appropriate care, but they have little influence over prison policies or officers' attitudes.

References

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