Providing neurologic care in criminal systems and state mental hospitals

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Summary

As health care laws and payment structures change in the near future, neurologists may pursue other practice settings in which to provide care as a way to diversify their practice. Here we describe the challenges and opportunities involved with working in correctional and state mental hospital systems compared to a typical private practice: logistical challenges, patient and provider safety, patient characteristics, and cultural differences. Neurologists may take these factors into consideration when choosing whether to add this health care setting to their current practice.

There are approximately 1.5 million¹ people in the United States prison population in state and federal settings, ranging from city and county jails to high-security federal prisons. In addition to individuals in the criminal justice system, there are approximately 49,000² beds in the nearly 200 state mental hospitals operating across the country. A study population sampled in Texas found that nearly one-quarter (24.5%) of inmates have at least one chronic condition.³ The incarcerated population is one of very few in the United States with a constitutionally guaranteed right to health care through the Eighth Amendment of the US Constitution⁴ (although prisoners may still be responsible for some costs, such as copays and over-the-counter medications⁵). This has interesting effect on outcomes, with one study showing lower mortality due to diabetes, cardiovascular disease, lung cancer, and respiratory disease in African Americans compared to expected age-specific rates in that state.⁶ Providing care in such settings represents a unique opportunity for the practicing neurologist.

There are various forms of incarceration involving individuals from both the criminal and civil systems. Jails house those who are accused of a crime and may be pending trial, whereas prisons typically house persons who are currently serving a sentence following conviction for a

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crime. State mental hospitals typically serve both civil and criminal systems. Persons adjudicated “not guilty by reason of insanity” or “incompetent to proceed” (ITP) by the criminal justice system may be committed to state hospitals. State hospitals frequently perform evaluations for competency to proceed and provide treatment to restore competency among those previously adjudicated ITP. State hospitals also frequently house and treat persons civilly committed to treatment.

Both civil and criminal systems represent a chance for practicing neurologists to serve a different population than they might otherwise. Working in these settings provides the opportunity to learn about the correctional and/or civil systems in depth and provides unique experiences. However, there are also notable challenges inherent to work in such settings. Whether the practice constraints in either the correctional or civil mental health settings will be a good fit for a neurologist will depend on both the individual facility chosen and the preferred practice style of the neurologist. In the Neurology Department at the University of Colorado, we have experience treating patients in both the civil mental health and the criminal justice systems, including incarcerated patients receiving care at the county hospital and patients receiving care at the state hospital following commitment stemming from civil or criminal proceedings. According to one study, diseases of the nervous system have a 4.2% prevalence within one prison system in Texas.⁷ While formal prevalence data are unavailable, our consults follow fairly typical patterns one might see in any neurology practice, with headaches, seizures, movement disorders, neuromuscular, stroke, and trauma being our most common consults. We encounter consults involving a spectrum of behavioral issues, including self-directed violent behavior, assaultive behavior, and malingering.

Logistical challenges to providing care

First, there are often geographical challenges relating to the need to travel to the facility, as security and/or legal consideration may preclude patient travel. Depending on the physical location of the facility, this may involve a considerable amount of travel time for a limited number of consultations. Urgent consults are often difficult to arrange.

If a patient does need urgent evaluation, he or she is sent to the local hospital’s emergency department due to both the unavailability of the consultant and the limited number of diagnostics available in-house. In our experience, contracts for payment for work in these systems are often based on a prearranged frequency of visits to the facility rather than per patient. Once the contract is successfully negotiated, this process is quite straightforward and compensation is reasonable for the amount of time involved. Typically institutions are not large enough to need a full-time neurologist, so contracts may request weekly or monthly visits. There may also be opportunities for research at a facility, but local review board protocols will need to be observed.

Considering their residential status, the availability of the patients can be fairly limited. The facility may be on lockdown for security reasons or a patient may be away at court or other activities that may take precedence over a consultation. These obstacles are outside of the practitioner’s control and are frequently inflexible, requiring accommodation on the part of the provider. Security issues may require physical restraints, necessitate the

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presence of security/correctional staff, or limit access to examination tools; neurologic assessment often requires flexibility and creativity, or even compromise. This adjustment can be difficult for many providers who are understandably used to patient care being the preeminent goal (as opposed to security).

Despite the drawbacks of travel time and patient unavailability, there are some logistical advantages that can simplify consultations. Individuals are monitored at all times, often including video, and this can aid in the diagnosis of various neuropsychiatric conditions, such as seizures, nocturnal events, movement disorders, and malingering. Staff (especially at state hospitals) caring for these patients are often both medically trained and legally savvy. They are readily available to provide input and observation, enabling eyewitness accounts of behaviors or episodes at the time of the consultation. Staff members often have considerable familiarity with patients, such that subtle changes in behavior or even gradual changes over time can be detected and reported to the consulting physician.

Another useful feature of the residential setting is the regimented administration of medications over long periods of time. Not only will patients be given their medications on time and in a regular manner, but extensive documentation is available for all as-needed medications. This can be useful when looking for causes of mental status changes, assessing severity or frequency of breakthrough pain, or finding medication changes responsible for new-onset seizures or other changes in health.

Unique patient characteristics

There is a wide range of neuropsychiatric illness in terms of both diversity and severity in criminal and civil systems. Because of this range, consultation frequently involves assessing change from the individual's chronic neuropsychiatric status or new behaviors superimposed on an already pathologic baseline.

The nature and severity of neuropsychiatric illness in these populations may present unique challenges. Patients may refuse to see the provider at any time. This may be due to mental health issues (increased psychosis or paranoia) or distrust of providers, which may also result in patients' terminating the visit prematurely. The examination and history may be limited to a brief greeting and seeing the patient ambulate. Intractable aggression or severe neurocognitive impairment may preclude typical approaches to history-taking and physical examination. Safety will at times require multiple security personnel and physical restraints, or even conducting the evaluation through the window of a locked door.

Adaptive practice may mean that history is only available via chart review and consulting with staff members, some of whom may have known the patient for years or through multiple admissions. Information from ancillary staff can be critical for getting a history, especially when the patient is unable or unwilling to speak. Such challenges stem from a diverse array of neuropsychiatric conditions and psychosocial circumstances, some of which threaten the ability to cooperate (i.e., psychosis) and others of which affect willingness to cooperate (i.e., personality disorders, malingering). Discerning between volitional behaviors and genuine signs and symptoms can be difficult.

An additional challenge to providing care in these populations is the rate of malingering, which is estimated to be between 8% and 21%.⁸ Patients may have limited control over the circumstances of their lives and may be seeking additional privileges or exemption from facility requirements. While the clinician must be aware of this possibility, it is also important not to let the possibility of malingering dictate clinical decision-making. Maintaining a compassionate relationship in the setting of potential malingering can be challenging. Reports of malingering should be considered with caution when completing a consult in these settings because problems such as aphasia may be misinterpreted by those with little neurologic training. Malingering often precipitates all-or-nothing thinking among staff; in reality, legitimate neuropsychiatric illness and malingering may coexist. If malingering is suspected, reports from multiple staff members, video surveillance, neuropsychological testing, consultation with a psychiatrist, and a careful exam will frequently be enough to settle a question of malingering of a neurologic disease.

Safety concerns

There are safety issues a clinician may want to consider before deciding whether to pursue work in the corrections system or the state mental health system; however, in one study in a forensic psychiatric setting, most mental health workers reported a safe hospital environment and felt confident in their ability to work with aggressive patients.⁹ The issues of sex, experience, and perceptions are more fully reviewed elsewhere.¹⁰ While some patients may be at increased risk for violence, the awareness of this possibility is typically proportionally heightened in these facilities. Staff members are vigilant about safety at all times, and correctional officers are typically present or available for all interactions. This may limit the amount of information a patient is willing to divulge but offers the benefit of someone present with experience in recognizing and responding to a dangerous situation. Additional safety measures may include physicians being asked to leave their examination tools in secured areas and to not bring anything that could be used as a weapon into the examination room. This decision is typically made based on the individual patient as well as facility policy. If a patient is more volatile than normal, the clinician will be informed of this before seeing the patient and instructed in the safest way to proceed with the consult. This may include examining the patient while he or she is in arm or leg restraints, conducting the examination with multiple officers present, or interviewing the patient through a window with clear instructions not to enter the same room as the patient. In this case, the physical exam must be done with verbal instructions alone and without physical contact. In our experience, deferring to security personnel on safety determinations is advisable to ensure a safe encounter, whether this is a recommendation to leave shackles in place throughout the examination or to limit the encounter to a discussion through the glass window in the door. Longer-term safety issues are less of a concern for the consultant because patients are typically not able to contact or locate the physician directly and instead route all communication through the facility staff. Prescriptions are also typically managed by the internist, so patients do not direct medication-seeking behavior at the consultant.

In reality, most encounters in these settings are as safe as any office encounter. The clinician must adapt to the priorities of the facility, which are safety of patients and staff first and a complete physical examination second. With time and experience, the clinician can also learn to develop and recognize a “gut” feeling of safety as well as the officers and staff of the facility, a skill that can be easily applied to other outpatient and inpatient settings.

Optimizing the safety of a patient with neuropsychiatric impairment may represent a novel challenge given the potential for violence and abuse within prisons and other forensic facilities. Inmates with cognitive or physical impairments may be easy targets for other inmates and may need special monitoring or living arrangements in order to maintain their safety. In other situations, inmates who are impulsively aggressive because of their neurologic problems (such as frontal lobe injuries) may require special considerations to keep other prisoners safe from

disinhibited behaviors. Participating in these discussions can be a new and difficult experience for providers.

Cultural differences

There may be a kind of “culture shock” for physicians working in these settings for the first time. Being subjected to the same search and security measures as staff and visitors upon entrance to a facility can be jarring.

Finally, consulting neurologists must be very clear in defining their role. Clinical care and medicolegal opining are very different functions. The former involves a typical doctor-patient treatment relationship and the customary hierarchy of medical ethics: autonomy, nonmaleficence, and beneficence. Medicolegal evaluation typically involves a fiduciary responsibility to a third party (i.e., a court) and prioritizing truth, objectivity, and respect for persons. Mixing clinical and medicolegal roles may preclude doing either optimally. The neurologist serving in a clinical role should be aware of the legal backdrop. Offering medicolegal formulations in the record (i.e., frontotemporal dementia caused the criminal act) may precipitate undesired involvement in legal proceedings.

DISCUSSION

Providing care in a prison or state mental hospital setting can represent a unique opportunity for clinicians to learn about a new system of health care. As with any new system, there are positive attributes as well as obstacles clinicians will face in the course of doing their best to provide quality clinical care to each of their patients. Prisons and mental health institutions allow clinicians to work with a group of patients that have different backgrounds and histories from their normal clientele as well as diverse mental and emotional capabilities and baselines. However, in these settings where the patients are monitored continuously and staff often get to know the patients well, it can be a gratifying experience to provide care in the setting of difficult life experiences and challenging psychosocial circumstances.

For further information, we suggest discussing opportunities with the medical director of any facility.

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