Intensive Medical Management

How to handle prisoners who self-mutilate, slime, smear, starve, spit, swallow and scratch

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Slides and Handouts available to download at:

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Case Report on MV
- White male in mid-20's with severe paranoid schizophrenia
- Acute exacerbation of psychosis
- "Causing problems with count for 4 days"
- MD phone order obtained to place him in restraint chair

The Forced Cell
Another Schizophrenic Subdued

Death of MV
- Released from chair after 16 hours
- Taken to shower to clean up
- Prisoner collapses, ACLS initiated
- Prisoner pronounced dead
- Autopsy reveals massive pulmonary embolism

Public Relations Nightmare
- Executive Director of Prison resigns
- Psychiatrist investigated by DOPL
- Medical Director tried in the press, takes job elsewhere
Legal Nightmare

- Legislature launches full investigation of Department of Corrections
- Protracted lawsuit settled out of court

Local, Regional, and National Media Hysteria

The Nightmare Continues

- Abu Ghraib scandal
- Guantanamo Bay
Lessons Learned

- The old saying "This is going to hurt me more than it will hurt you" holds much truth.
- Restraint and forced medication patients frequently have adverse or fatal outcomes.
- Prisoners managed this way frequently end up in court as plaintiffs.
- Legal settlements for mistakes are expensive.
- Only defense is to adhere to community standards and to document adequately.

Brief History

- When I first started......
- Physical restraint was COMMON.
- Restraint chair used routinely.
- Mentally ill patients restrained for WEEKS.
- Restraint initiated by officers; no medical involvement.
- Mirrored what was going on nationally.
- I was personally horrified and as a baby medical director I was responsible.....

A Lot Has Changed

- HCFA issued rules regarding restraints.
- Federal reaction to an appalling national practice resulting in excessive deaths.
- HCFA mandated increased supervision by physicians, nurses and defined types of interventions.
- Jail responded to HCFA rules by changing policies.
Changes over time to IMM

- Added nursing supervision of patients in restraints
- Placed time limits on restraints
- Changed the types of restraints used
- Added physician involvement if restraints continued past 2 hours
- Changed longer restraint into a medical treatment done in a medical setting

Community Response to HCFA

- Medical community nationally reacted vigorously to new HCFA rules
- Seen as way too much of a correction
- Rules accomplished intended result: USE MEDICATION, NOT RESTRAINTS!!!
- Rules have softened a bit over time due to positive results from medication management

Use of Force in Mentally Ill

- Mentally ill patients are medically fragile
- Psychiatric medications have known cardiac implications
- Mentally ill frequently have cardiomegaly and CAD
  - diet
  - meds
  - street drugs
- Mentally ill patients cannot handle significant physical stress—they die!
Important Definitions

“Intensive Medical Management”
- Physical restraints
- Forced medications
- Involuntary seclusion (full safety precautions)
- Does not pertain to:
- Custody restraints
- Adaptive devices
- Acute medical settings like IV armboards, etc.

Policy Must Balance Interests

- Meet the legitimate custody interests of:
  - Safety and security
  - Good order and discipline
  - Standardized policies and procedures
- Accommodates the needs of prisoners by:
  - Providing reasonable management alternatives with procedural safeguards
  - Variable alternatives based on prisoner compliance
  - Provide for safety and well-being of all prisoners

Community Standard for Intensive Management

NCCHC Essential Standard J1-01
- Must be ordered by physician or licensed independent practitioner
- Order should not exceed 24 hours
- 15 minute checks by health-trained personnel
- No unnatural positions
- Handcuffs or leg shackles inappropriate
- NCCHC standards are broad and not directive
Medical Orders

Must include:
- Date and time order written
- Maximum duration of restraint / seclusion
- Parameters for reassessment by RN
- Specific type of restraint / seclusion to be employed
- Appropriate observation status
- Special precautions, if any
- Physician signature (or for verbal order, name of physician and RN who took order)

Medical Orders

- There are no standing orders or PRN orders for restraints, seclusion, or forced medications!
- Each order expires after 4 hours for adults, after 2 hours for adolescents (9 to 17), and after 1 hour for patients under 9
- Orders may be renewed for 24 hours before another face-to-face physician assessment is required

Documentation of Intensive Medical Management

- Incident Report Form
- Intensive Medical Management Flowsheet
- Intensive Medical Management Daily Log
- Medical Record
Intensive Medical Management Flowsheet

- Provides outline for initiating Intensive Medical Management
- "Idiot Proofs" nursing documentation
- Ensures continuity of care
- Legally defensible documentation

Alternatives to Intensive Medical Management

- Escalation Cascade
  - Removing prisoner from stimuli
  - Communication and verbal calming
  - Mental health referral with crisis screen
  - Voluntary medication
  - Intensive Medical Management

Alternatives to Intensive Medical Management

- Crisis Intervention Training (CIT) Academy
  - All officers who handle mentally ill patients required to be certified
  - Correctional based program
  - #1 officer training opportunity
  - Pre vs. post CIT implementation study showed 95% reduction in uses of force against mentally ill
Perceptions of Winning with Difficult Patients

- Custody Perspective
- Health Services Perspective

Know Thy Patient

- Axis I
  - Early recognition and diagnosis
  - Rapid stabilization with medications
  - Therapy teams and therapeutic milieu
- Axis II
  - Secondary gain—what are they after?
  - Must avoid the power struggle

Case Stories

- Evisceration case
- Privacy case
Know Thy Environment

- Jails
  - Diversion at the door
  - Short term management
  - Crisis stabilization
  - Coordination with community MH resources
- Prisons
  - Long term management and behavior optimization
  - Partnership with outside consultants
  - Partnership with advocacy groups

Relationship Tricks of the Trade

- TRAINING of nurses
- TRAINING of officers
- Develop relationship and treatment team approach with custody
- Nursing supervisors enforce clinical objectivity
- Actively seek relationships with advocacy groups and judges

Treatment Tricks of the Trade

- Adequate training
- Rubber Posey Restraints
- Restraint Board
- One-to-one nursing
- Emotional leashes
Medication Magic

- Olanzapine (Zyprexa)
  - 20 mg IM or PO
  - Landing time 47 minutes
  - Tend to favor for manic-agitated patients who are not violent
- Imodium 5 mg IM injection
  - Haloperidol (Haldol) 5 mg
  - Lorazepam (Ativan) 2 mg
  - Diphenhydramine (Benadryl) 50 mg
  - Landing time 36 minutes
  - Tend to favor for violent patients on meth, spice, bath salts

Victory in Perspective

- Decreased financial costs
- Minimize hospitalizations
- Reduce ER trips
- Effective utilization of medications
- Effective utilization of bedspace and staff resources
- Minimize violent encounters between custody and prisoner
- No litigation or ongoing battles with advocacy groups

Lessons After 6 Years

- Biggest challenge is to change mentality away from the punitive to the protective
- CIT training for officers works!!!
- Separation of custody and medical restraints DOES work
- Following the least-restrictive cascade rarely culminates with intensive medical management
- This methodology results in FAR LESS institutional disruption than frequent restraints
- Focuses mental health care on prevention and primary care instead of crisis management
Starvation Patients

- Manipulators
- Housing, privileges, diet
- Seriously mentally ill
- Paranoid
- Negative schizophrenic symptoms
- Eating disorders (anorexia, bulimia)
- Religious but reasonable
- Scheduled religious fasts, end point defined
- Conscientious Objectors
- Raw but difficult

Starvation Timeline

| Day 1-3 | Documentation of participation, chart review, medication adjustment (insulin, antacids, nasals, diuretics) |
| Day 4-14 | Daily nursing assessments, MD evaluation, possible forced assessment, labs |
| Day 15-20 | Daily nursing assessments, admission into higher levels of care, forced assessment, labs |
| Day 21-34 | Admission into higher levels of care, capacity determination, forced assessment, labs |
| Day 35+ | Admission, capacity assessment, intervention as allowed by law / ethics |

Starvation Assessments

- BMI tracking
- CBC
- CMP
- Magnesium
- Phosphate
- Pre-albumin
Re-feeding Syndrome

- Symptoms can occur suddenly
- Nausea, vomiting, cardiac failure, hypotension, electrolyte abnormalities
- Markers: hypophosphatemia, hypokalemia, thiamine deficiency, CHF, peripheral edema
- Risks determined by length of fast, % of weight loss, labs
- When fast ends, draw labs, start refeeding slowly, monitor patient!

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