Locus of Control

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“What were you hoping would happen when you overdosed?”
“I thought I was going to go to sleep and not wake up.”
“What did you think was likely going to happen?”
“Something. Not sure what, though.”

From a medical toxicology perspective, he did not require any interventions beyond some initial serology, an EKG, and twelve hours of monitoring; the same recommendations as the last presentation. He had taken the same pills, after all. Fortunately, neither had been a lethal ingestion. But what about the future?

“This is your second overdose in the past few months. How can we help prevent this from happening again?”
“Prevent?”
“How can we help to reduce your risk of overdosing again?”

The chains on his legs rattled as he repositioned. “No way you can help me.”

Up to a certain point, that was true. He had presented last night from the penitentiary after an intentional overdose on his various medications, which he had been storing for a week beforehand. The circumstances of this episode were similar to the previous one: he wanted to cancel his transfer to another facility where he feared violence from gangs as reprisals for his prior crimes.

“So, you’re overdosing to kill yourself because you’re worried that you will be killed by someone else. Help me understand that.”

“I’d rather kill myself than let someone else have the pleasure of killing me, it’s that simple.”

He was now medically cleared, and psychiatry had recommended discharge back to the penitentiary with suicide precautions. Of course, he had discovered ways to thwart those precautions before, and he might do so again in the future. We had treated the acute overdose, but as medical providers, we were seemingly powerless to prevent future ones. In his limited freedom, the incarcerated patient tragically leveraged the little power that he had access to: his own body.

This was not the first time we as medical providers had been frustrated by the correctional system. Some of us have provided care for patients within the prison, where our ability to provide care was also limited. Many patients do not receive medically assisted withdrawal or medication for substance use disorder. Some patients have recursive presentations to the emergency department (ED) as they undergo opioid withdrawal in jail, receive buprenorphine in the ED, and then undergo withdrawal shortly after returning to jail because of a lack of buprenorphine on formulary. Formulary restrictions are legion: buprenorphine, methadone, naltrexone, bupropion, quetiapine, gabapentin, diphenhydramine, benzodiazepines, and psychostimulants. Several patients with thought disorders are on dual or triple antipsychotics because clozapine is not on formulary. Additionally, too many patients want to be prescribed ziprasidone just for the snack, so now that is gone as well. Many of these formulary restrictions are intended to prevent misuse or diversion by the patients, but it is also true that these restrictions can be protective to some patients who might otherwise be coerced or threatened by other inmates to divert medications.

This was not the first time that we had seen an incarcerated patient present because of an overdose. In many cases, the patient intentionally overdosed in...
a suicide attempt. In some cases, patients were found unconscious after an unknown downtime, later to be discovered to have unintentionally overdosed on drugs smuggled into their cell. In other cases, the patient reported an intentional ingestion, but the nature of the report raised concern for secondary gain, with the apparent objective of having a few days respite in the hospital before returning to the correctional facility. Many of these patients have presented for overdose many times over the course of their sentence, requiring varying levels of intervention, from observation to critical care. Some returned to prison. Some died.

Among incarcerated patients, the chief complaint of “overdose” has a myriad of possible etiologies and outcomes, and so many of the risk factors are rooted in the incarceration itself, leaving clinicians powerless to help. Incarcerated patients are at significantly increased risk of death from overdose, with most overdoses occurring with the use of psychotropic agents. This is unsurprising considering the rise of overdoses occurring with the use of psychotropic agents.

Of course, few correctional officers work at a prison to be mental health providers, and few physicians work at a hospital to be jailers. As the toxicology consult team left the patient’s room, one of the officers followed us out. He was eager to talk with us but spoke in hushed tones. “You wanted to know how to reduce his overdose risk, and I can tell you, there’s only one way.” We listened without offering a response, and he whispered his secret. “You have to understand that he is going to one of the most dangerous yards in the country. I’m talkin’ about two-to-three stabbings a week. We try to protect him, but prisoners have their ways. I’m just sayin’. The only way to protect him is to ‘redesignate’ him, that’s the word, ‘redesignate,’ to what’s called a ‘drop-out’ yard, without gangs. He’s going to keep overdosing until he gets to a drop-out yard where he can be safe.” We stared at the officer, not knowing what to say, if we were legally permitted to say anything at all. “He’s tried everything to get transferred, but no doctor has recommended anything. I’m tellin’ you this so maybe y’all can try to do something from the medical side.” And with that, the officer stepped back into the patient room, leaving the consult team silent in the hallway.

What to do with this information? Should we leave a line in the consult note: “In evaluating this patient’s current and prior presentations, the most impactful intervention that would reduce his risk of future overdose would be to transfer him to a less dangerous yard in prison.” Will that be read by anyone?

Should we make phone calls, write letters, send emails? Will anyone respond? There are limits to the benefit of a bedside consult when the means of truly healing a patient lie in systems far beyond the physician’s control.

As we considered how best to help the patient, we wanted to enlist a larger medical audience to draw attention to the problems that arise at the interface of the correctional and health care systems. So, we asked the patient if we could draft his story and share it for his sake and the sake of others who face similar sufferings. Maybe if others could hear his story, we could make some progress in caring for the incarcerated patient.

Writing this, we feel a bit like an attorney who is a “zealous advocate” for the client, which reflects the adversarial mentality that can arise between medicine and corrections, where any collaborators, as with the correctional officer in our case, might be perceived as a “double agent.” Why is that?

On the one hand, there is a species of learned helplessness that comes with caring for incarcerated patients. The correctional system imposes limits on the physician’s ability to provide care, and there is seemingly little the physician can do to change that. On the other hand, there is a splitting phenomenon that can occur between the medical providers and correctional providers, which can result in systemic antagonism. In this dilemma, as in our case, incarcerated persons sometimes take desperate measures to advocate for their own interests, which can lead to tragic consequences.

The current state of interaction between the medical and correctional systems often breeds frustration in all parties involved, in part because of an apparent misalignment of priorities. This dilemma is in turn partly grounded in how the incarcerated individual is perceived, whether as patient or as inmate, and by whether a physician or a correctional officer is caring for the person at any given time.

Caring for patients in the correctional system is a balancing act: practicing the standard of medical care, maintaining patient safety, reducing risk of prescription diversion and misuse, and mitigating patient gamesmanship. Too often, these goals are
considered mutually exclusive, or clinicians, correctional officials, and incarcerated patients are communicating at cross-purposes, if at all. How can medical and correctional staff respect the responsibilities of their professions while working toward a mutual understanding of how to help the incarcerated person in a way that maintains safety and dignity?

There is no easy solution, but the conversation must begin somewhere.

As we continued to contemplate whether to write an order to the prison for the patient to be redesignated to a drop-out yard, we found ourselves back at the bedside. The patient was signing the consent form for us to write this manuscript, adding, “My story could help a lot of people.”

References