Collaborative Care in a Rural Prison: An Integrated Approach to Geriatric Psychiatry

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Outline

Overview of prison and prison healthcare

Introduction to prison mental health services

Geriatric care in prison

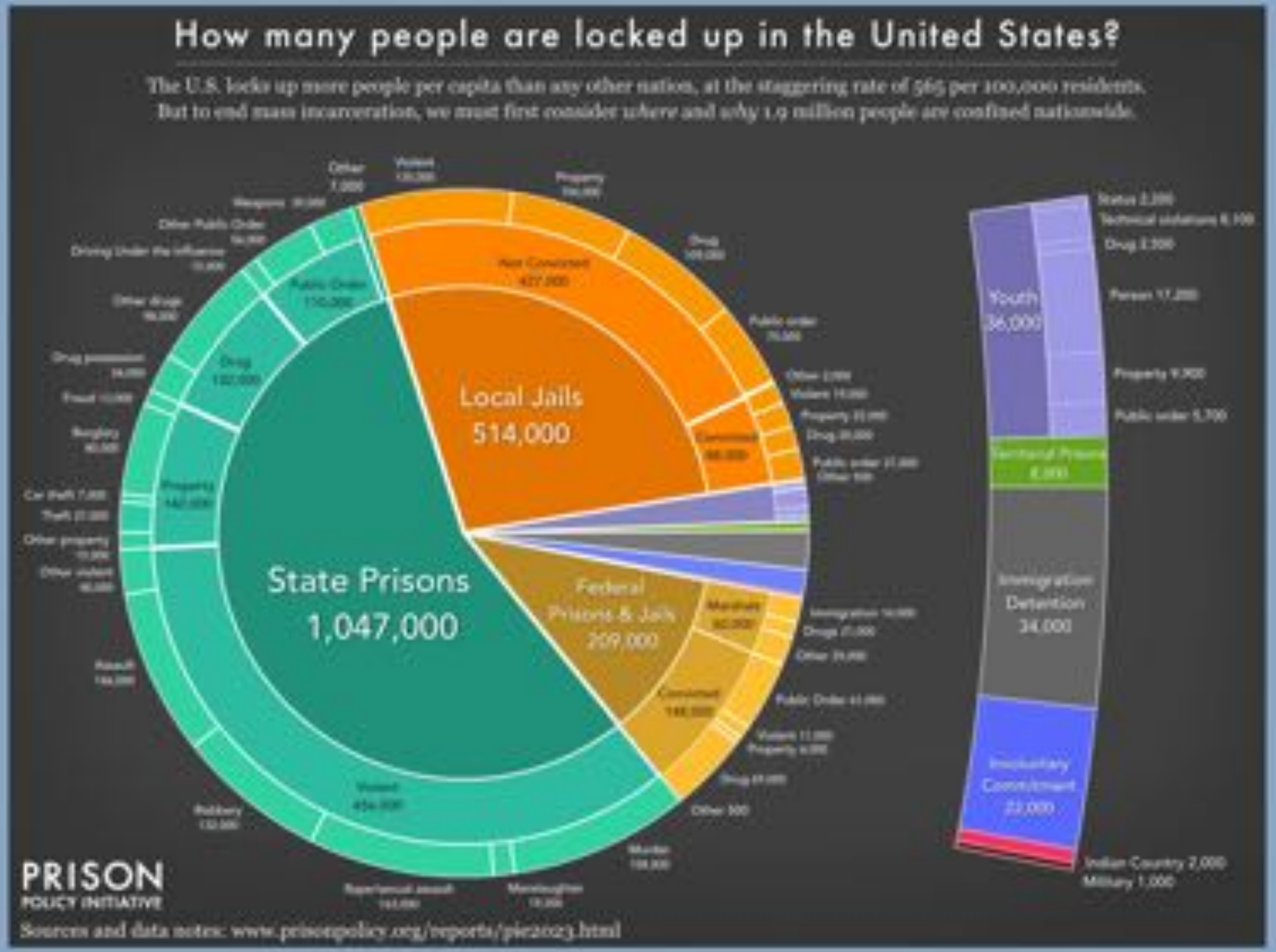
Geriatric case presentations

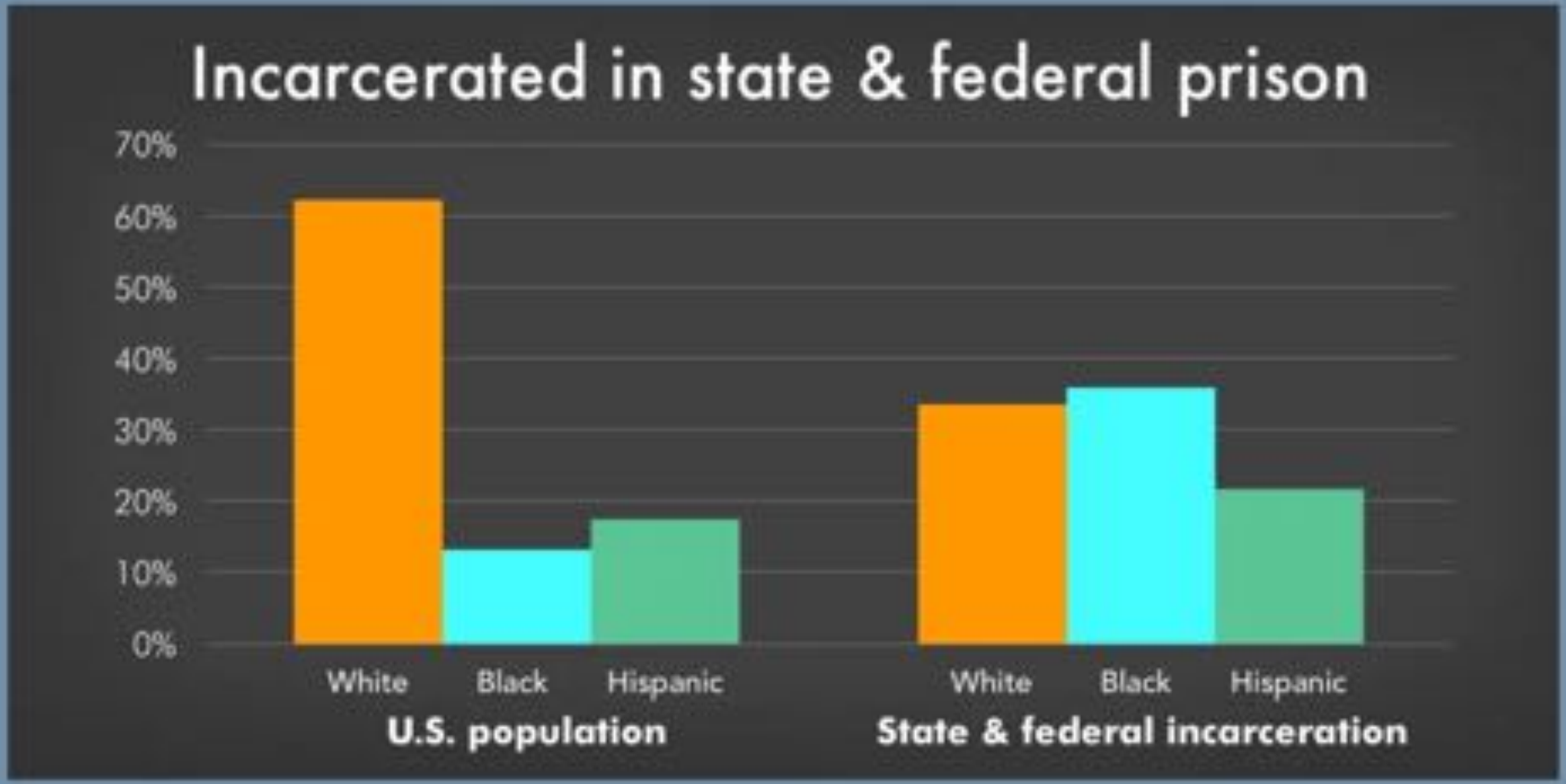
Questions and discussion

Learning objectives

1. Understand how care is provided in prison and how healthcare is delivered in prison in Washington state
2. Be able to identify risk factors for accelerated aging among people with a history of criminal legal system involvement
3. Understand some of the challenges to providing medical and psychiatric care to geriatric incarcerated individuals
4. Gain an understanding of how collaborative care works in carceral settings

Overview of prison and prison healthcare


How many people are locked up in the United States?
The U.S. locks up more people per capita than any other nation, at the staggering rate of 565 per 100,000 residents.
But to end mass incarceration, we must first consider where and why 1.9 million people are confined nationwide.
Local Jails
514,000
State Prisons
1,047,000
Federal
Prisons & Jails
209,000
Youth
36,000
Immigration
Detention
34,000
Involuntary
Commitment
Indian Country 2,000
Military 1,000
PRISON
POLICY INITIATIVE
Sources and data notes: www.prisonpolicy.org/reports/pie2023.html



Infographic: Prison Policy Initiative

Jail	Prison
Local (city, county, town)	State or federal
Pre-sentencing Post-sentencing (short sentences)	Post-sentencing (longer sentences)
Innocent, misdemeanor, felony	Felony

King County Jail

Photo: Seattle Times

Monroe Corrections Center

Photo: KOMO News

Prison and jail in Washington

Washington Dept of Corrections

Mean length of stay: 29.5 months
Number of people incarcerated: 13,017
Number of people released in 2024: 5235
Return to prison within 3 years: 24.9%

King County Jail (largest jail)

Mean length of stay: 46.1 days
Number of people booked annually: 15,641

Sources: WA DOC Fact Card; King County Jail Detention and Alternatives Report

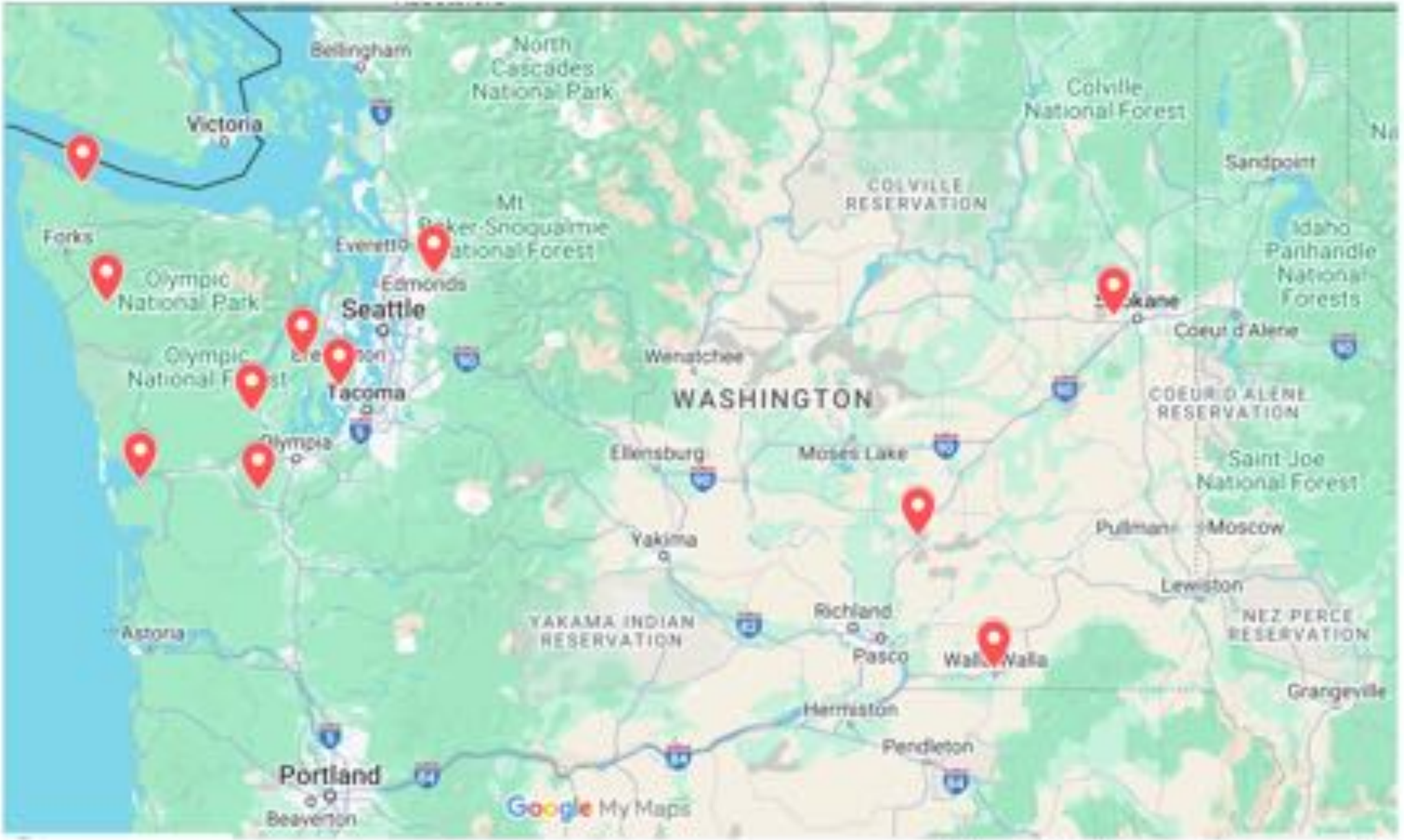


Photo: Washington Department of Corrections

Who is in prison in Washington?

- 93.9% male
- 54.8% white, 18% black, 5.3% AI/AN
- Mean age: 41.5 years
- Serving life without parole: 3.7%
- Over age 55: 15% - 2061 people
- Over age 70: 2.7% - 373 people

Coyote Ridge Corrections Center (photo: Correctional News)

Source: WA DOC Fact Card

The basics of prison healthcare

Insurance terminated*

Single payer health system

Varying care models

Prison or jail system provides or funds care

Constitutional right to health

Estelle v Gamble (1976)

POSITION PAPER

Annals of Internal Medicine

Health Care During Incarceration: A Policy Position Paper From the American College of Physicians

Newton E. Kendig, MD; Renee Butkus, BA; Suja Mathew, MD; and David Hilden, MD, MPH; for the Health and Public Policy Committee of the American College of Physicians*

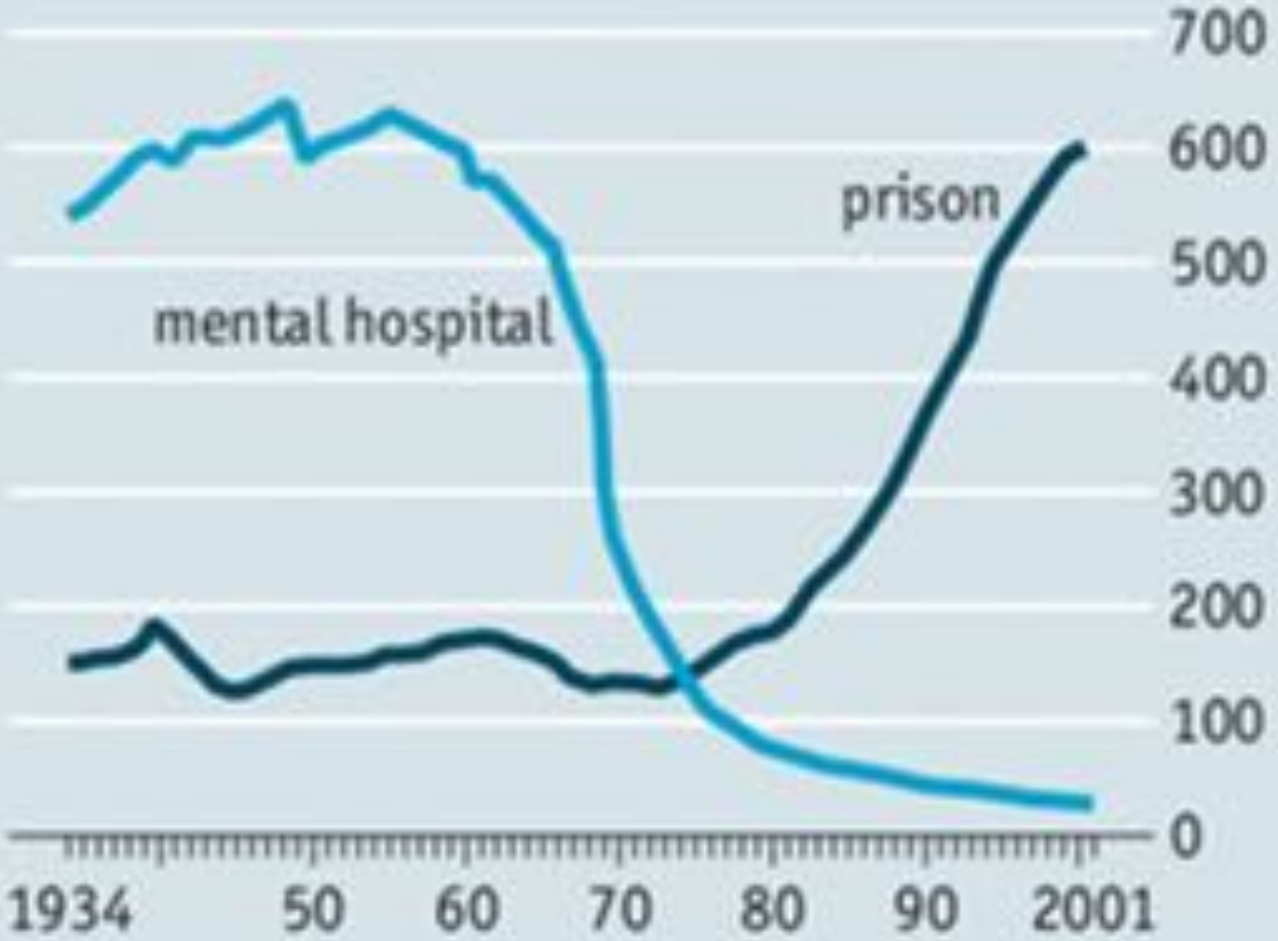
"The quality of care and ethical principles of professional engagement must be consistent with that provided to community-based patient populations."

Introduction to psychiatric services in prison

Out of sight...

America's mentally ill held in:

Per 100,000 adults



Source: B.E. Harcourt, "An Institutionalisation Effect"

How many people in Washington have SMI?

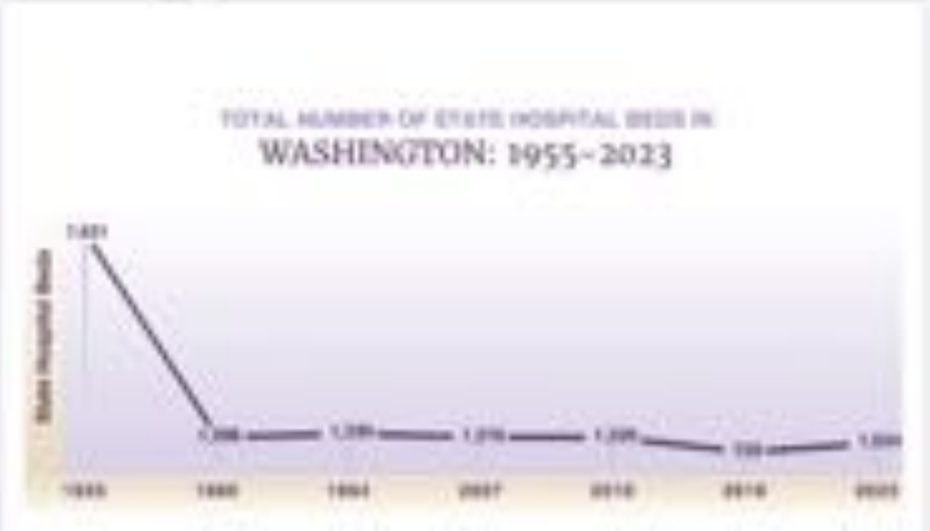
212,308

88,079

3.4%

What is SMI?

State psychiatric hospital beds in Washington



2023 total beds: 1,034

- Civil beds: 431
- Forensic beds: 603

2023 beds per 100,000 people: 13.3

Click here for more information about state psychiatric hospital beds in Washington.

WA Psychiatric Beds Report

A minimum of 50 beds per 100,000 people is considered necessary to provide minimally adequate treatment for individuals with severe mental illness. Washington fails to meet this minimum standard.

Fast Facts on SMI in Washington

Deinstitutionalization, outdated treatment laws, discriminatory Medicaid funding practices, and the prolonged failure by states to fund their mental health systems drive those in need of care into the criminal justice and corrections systems.

Prevalence of SMI in jails and prisons	Estimated number of inmates with SMI in 2021	State psychiatric inpatient beds 2023	Likelihood of incarceration versus hospitalization
15%	2,190	1,034	2 to 1

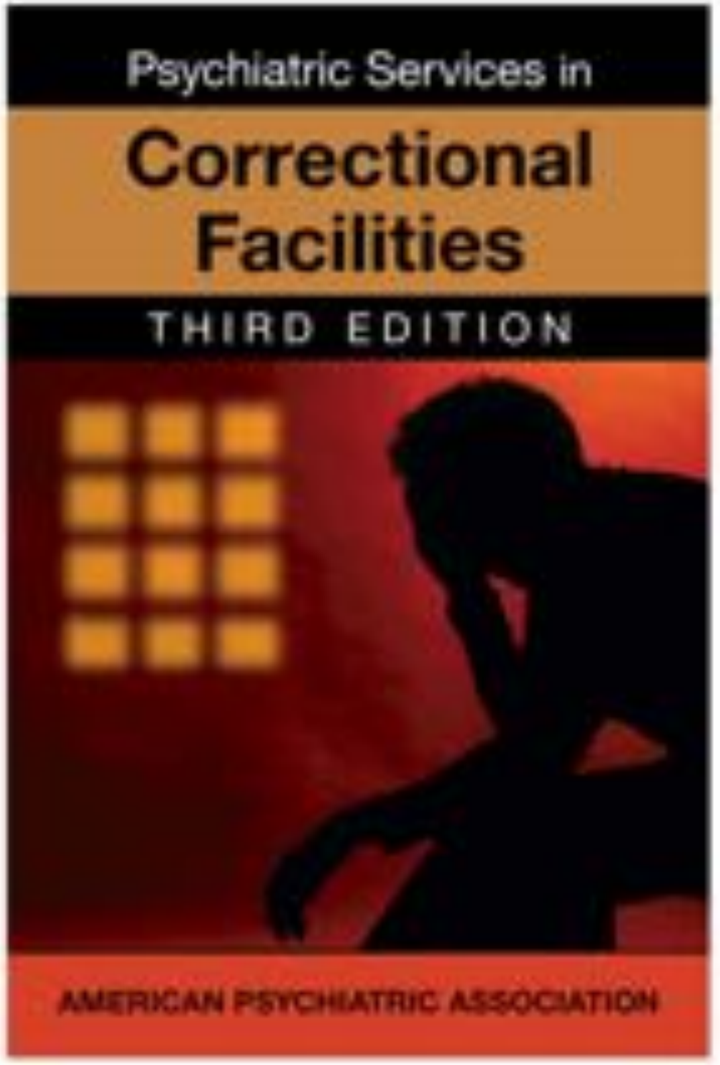
- Suicide is one of the leading causes of death in jails
- Suicide accounted for 30% and 8% of deaths in jails and state and federal prisons respectively in 2019
- Suicide rate in jail (46 per 100,000 in 2013) and in state and federal prisons (15 per 100,000)

APA Guidelines

- Fundamental policy goal for correctional MH care is to provide ***same quality of mental health services that should be available in the community***

- Policy goal is deliberately higher than the "community standard"- resource restrictions on community care can limit adequacy of available services

- Correctional systems provide additional challenges given that incarcerated persons have no options for care other than what provided in facility



Evaluation

- Triage at intake
  - In WA DOC, every new offender is screened live by a masters or above clinician
  - S code (1 through 5)
  - Illness not detected
    - May surface later – training and attitude of correctional officers crucial
  - Illness detected – more detailed evaluation
    - Outpatient level problem - general population
    - Grossly decompensated - acute care
    - Degree of disorder not clear – evaluation unit
    - Well known – direct to residential

Acute Care

- Location allowing for close observation
  - Available to all inmates
  - Usually infirmary or specialized setting
- Primarily for
  - Acute agitation or frank psychosis
  - Imminent DTS and DTO due to MI
- Treatment
  - Medication
  - Crisis evaluation and intervention

Residential Care

- Residential setting with tempering of custody orientation
  - Collaboration with custody critical
  - Good treatment enhances safety/security
- Needed at all custody levels (challenge for female prisons)
- Usual inpatient approaches are adapted
  - Level system
  - Recovery/rehab
  - Risk reduction
  - Individual and group therapy
  - Milieu (even have several therapeutic communities)

Challenges of Providing Care in Corrections

- Difficulty recruiting psychiatrists and other mental health providers
- Safety and security of the prison takes priority over routine psychiatric care
- Diversion of medications
- Limitations of confidentiality
- Operational limitations
  - Formulary restrictions
  - Structured time for medication administrations
  - Scheduled inmate movements
  - Unscheduled facility lock downs
  - Staff shortages


Unilateral
Bilateral

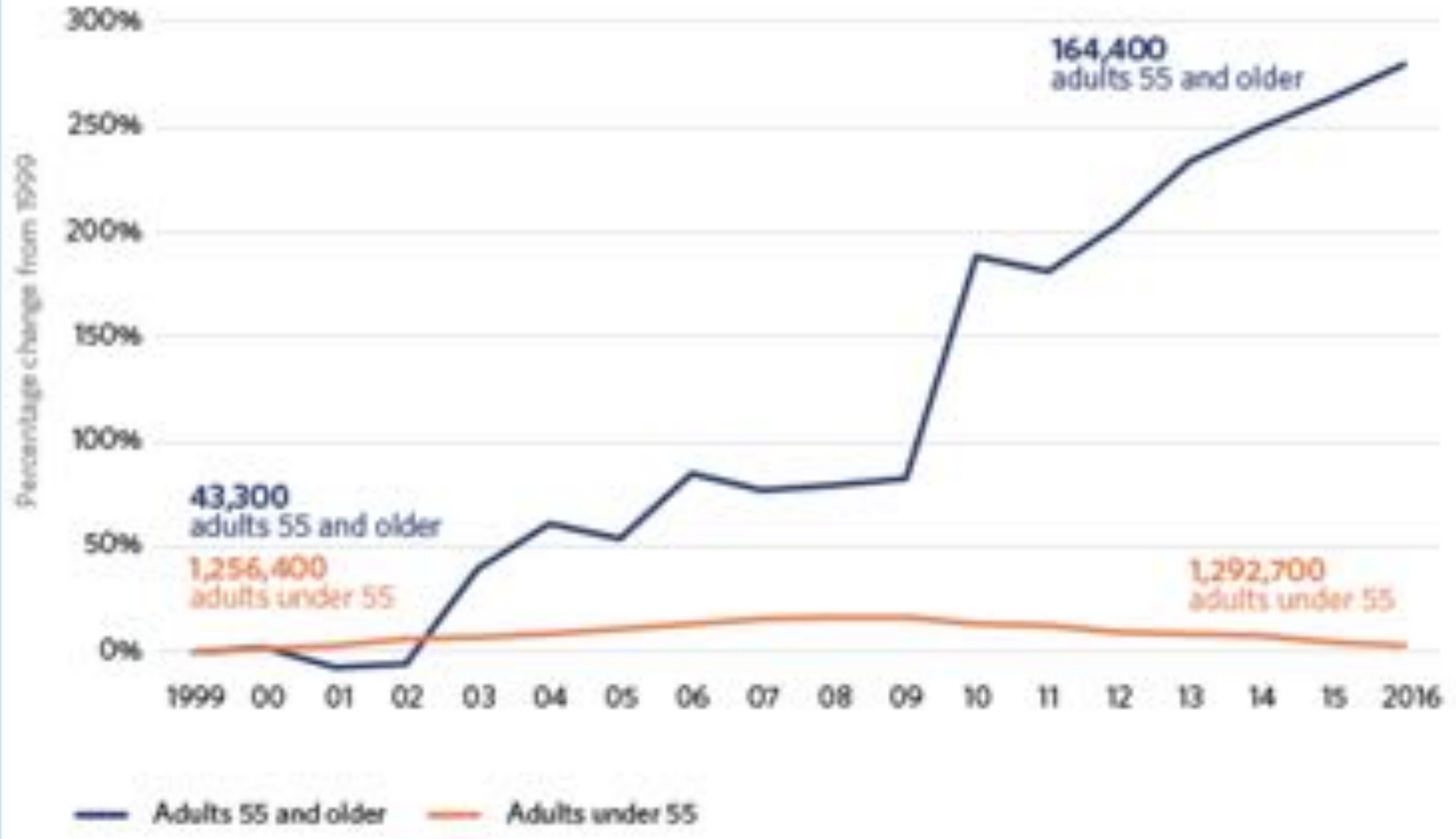
Summary

- Psychiatric treatment in DOC aims to be equivalent to community standards
- Prison is often one of the only times some of our SMI patients can receive psychiatric treatment
- While there are challenges, Washington state DOC has shown itself to be at the forefront of correctional psychiatric treatment

Geriatric Care in Washington Prisons

The Number of Older Prisoners Grew by 280%, 1999-2016

Percentage change in sentenced adults by age group



Source: Pew Charitable Trust

Condition	Jail	General population (demographically adjusted)
Hypertension	26.3%	13.9%
Diabetes	7.2%	4.5%
Cirrhosis	1.7%	0.1%
Asthma	20.1%	11.4%
HIV	1.3%	0.3%

Cohen et al., 2021

Accelerated aging among incarcerated people

Chronic disease, incarceration, poor healthcare access, low socioeconomic status, substance use, mental health conditions

Collaborative care program

The problem:

- Hard to recruit mental health providers to rural prisons to work in-person
- Telemedicine not good option for many geriatric, incarcerated people
  - Limited computer literacy
  - Dementia
  - Poor hearing

Collaborative care program

The solution:

- Collaborative model
- Every 2 week teleconference
- Who attends?
  - Psychiatrists and psychiatric NP
  - Sage medical providers
  - Sage psychologist (PhD)
  - Clinical pharmacist
- What happens?
  - Sage team presents cases
  - Psychiatric providers give input and recommendations
  - Sage providers prescribe

Collaborative care program

This is not a typical collaborative care program.

- Single payer health system
- Small, high-need population
- No structured measurement-based care
- More collaborative than general primary care in prisons

Sage Unit

Coyote Ridge Correction Center Connell, WA

CRCC MSU
“The Camp”

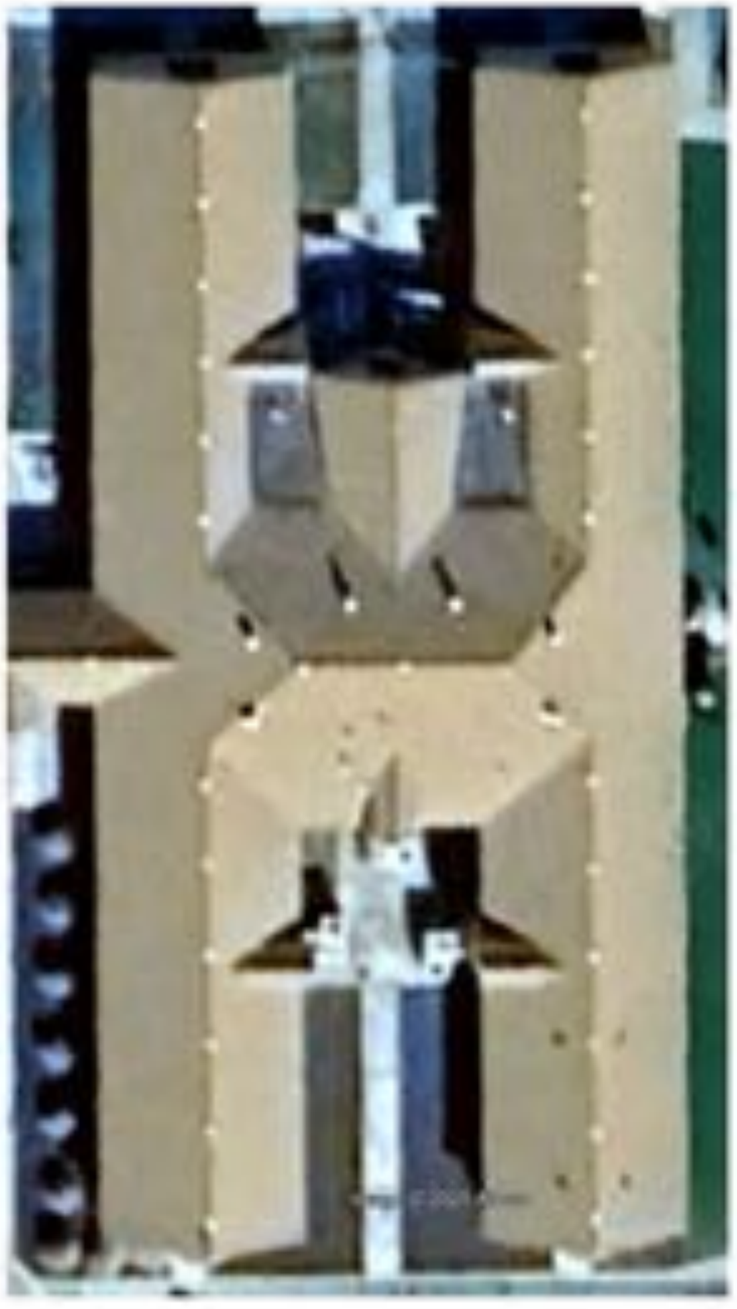
Minimum Security

Sage Unit

D Tier

B Tier

Sage East



C Tier

A Tier

Sage Unit

Four Tiers

- A Tier - 10 single man, wet cells
- B Tier - 9 two man, dry cells
- C Tier - 24 beds in open barracks style dorm
- D Tier - 24 beds in open barracks style dorm

Sage Unit

When this

Meets this

Sage Unit

- 76 Beds Total
- 52 Patient Beds
- Two Nurses
- Two to Three Certified Nursing Assistants
- Dedicated Pill Line

Sage Services

- Skilled Nursing Care
- Wheelchair/ Walker Friendly
- Medication Management
- Toileting
- Bathing
- Feeding
- Transferring
- Hospice

Path to Sage East

- Needs assistance with activities of daily living
- Primary care provider refers
- Sage East Screening Committee reviews
- Security staff review
- Final Custody Program Manager Approval

EMP

Extraordinary Medical Placement

EMP

- Governed by RCW 9.94A.728
  - Affected by permanent or degenerative medical condition
  - Low Risk to the Community
  - Death expected within 6 months
  - EMP will likely result in cost savings to state
- Cannot be serving life without parole or sentenced to death

EMP Process

- Patient is Referred for EMP
  - Self
  - Lawyer
  - Community member
  - Medical provider
  - Can be requested at any time

EMP Process

1. Medical provider writes a note and completes standard form
2. Multiple levels of internal medical and security review
3. Secretary of DOC Reviews

Case discussions

To protect the confidentiality of this vulnerable patient population, these cases are largely fictionalized with key learning points pulled from true cases.

Mr. Z

- 70yo man
- History of type 2 diabetes on insulin, hyperlipidemia, coronary artery disease with prior CABG, atrial fibrillation, and severe TBI due to assault just prior to incarceration
- No history of mental health conditions prior to TBI.
- Used methamphetamine, primarily smoked, for the 10 years prior to incarceration.

Mr. Z

- Shortly after incarceration, moved to inpatient unit as could not care for himself in the unit.
- Referred, then transferred to Sage
- Shortly after arriving in Sage, received infractions for yelling at staff when they approached him to offer care (assistance with bathing, toileting, etc.)
- Geri-psych consulted
- Starting on Depakote 250 PO TID for mood lability
- Behavior continues to escalate

Mr. Z

- Started on PRN quetiapine for mood lability and impulsivity
- Moved to an inpatient mental health unit at another prison for several months to optimize medication dosing and monitor behavior.
    - *Balance of patient wellbeing and protecting other vulnerable individuals in Sage.*
- Returned to Sage.

Mr. A

- 69yo man
- Serving a 6 year sentence, recently incarcerated
- Medical history of chronic back pain, heart failure, poor mobility (in a wheelchair, difficulty with ADLs), seizure disorder (no witnessed seizures), and type 2 diabetes.
- Carries many diagnosese from the community: schizoaffective disorder - bipolar type, borderline personality disorder
- S3 on initial prison health assessment

Mr. A

- Geripsychiatric team consulted for polypharmacy
- 20 oral medications (not including sprays, powders, creams)
- Patient wedded to medication, not interested in tapering
- Patient's primary concerns
  - Seeing demon faces x 30 years
  - Praying would make the demons go away
  - Began after traumatic events in childhood
  - Ongoing back pain

Mr. A

- Geripsych team made recommendations to consolidated medications
  - Support primary providers to deal with resistance
  - Concern that may have non-epileptic seizures so could reduce seizure medication
  - Started fluphenazine, which had previously helped the patient

Case 3

63 yo male with Huntington's Disease, depression, type 2 diabetes, and PTSD related to prior military service. He is has had a prior left lower extremity amputation due to a gunshot wound during military service.

Huntington's Disease

- Inherited progressive neurodegenerative disorder
- A mutation at the Huntington gene on the 4p chromosome
- Pathology not fully understood but thought to relate to the toxic buildup of Huntington proteins
- Autosomal Dominate - 50% of offspring affected
- In North America about 8.87 cases per 100k persons per year
- Symptom can develop at any age but 40s to 50s is most common

Suchowersky, 2025

Huntington's Physical Symptom

- **Chorea:** Uncontrolled, irregular, jerking like movements.
- Dystonia
- Abnormal Gait
- Eye movement slowing
- Loss of voluntary motor control
- Motor function slowly deteriorates until functional movement is lost

Suchowersky, 2025

Huntington's Psychiatric Symptoms

- Depression
- Apathy
- Anxiety
- Psychosis
- OCD
- Poor judgement
- Loss of insight

Suchowersky, 2025

Huntington's Progression

- Early Stage: Pretty functional, mild chorea, trouble with complex problem solving, depression common
- Middle stage: Cognitive decline, needs ADL assistance, difficulty walking - falls, psychosis affects the minority of patients
- Late Stage: Total care, total loss of motor control, bed ridden, early death
- Average onset to death is 10-20 years

Suchowersky, 2025

Back to Case 3

- The patient had been on and off tetrabenazine for several years
- Chorea progresses during his time at Sage
- He's having more difficulty with transfers from wheelchair (non-ambulatory due to amputation)
- Having some auditory hallucinations - difficult to characterize
- The care team is concerned about the patient's functioning

Case 3

Currently Taking

- Olanzapine for psychosis
- Amitriptyline for pain/sleep

Geri-Psych team is consulted

- Recommendations:
  - Start escitalopram for mood
  - Stop amitriptyline
  - Titrate off olanzapine
  - Start clozapine for hallucinations

Clozapine Monitoring

- CBC weekly x 6 M, then biweekly x 6 M
- CRP, Eos, Troponin QW x 6 W
- ECG for baseline/dose change
- Lipids 4 M after Tx starts

Effective for psychosis but requires close monitoring

Case 3

- Team concluded that labs could not be obtained reliably enough in Sage - clozapine not started
- The patient discussed again as a Geri-Psych team

New Recommendations

- If clozapine cannot be safely used, start loxapine
- The addition of cyproheptadine as combination has similar receptor profile as clozapine
- Titrate the dose up based on symptom
- No need for labs or close monitoring

About a Month Later

- Doing well on loxapine titration
- Very excited about new job
- Had a fall, likely due to chorea
- PCP team D/C'd baclofen as increases fall risk, not helping with pain

Back to Geri-Psych Team

- Continue titration of loxapine to 250 mg
- D/C olanzapine
- No change in pain or spasms off baclofen

Eight Months Later

- Chorea much worse
- Difficulty feeding himself now
- Had another fall

Update Geri-Psych Team

- Not getting as much benefit from the loxapine now
- Chorea are biggest issue currently

Update Geri-Psych Team

New Recommendations

- Decrease loxapine dose but continue
- Start Clonazepam 0.25 mg QD

The Current Situation

- Dramatic improvement in chorea
- Significantly improved motor function
- Able to feed himself again
- More independent with ADLs

Case #4: Mr. R

80 year old man with a history of hypertension, hypothyroidism, and Crohn's disease who was referred to Sage because he was unable to care for himself in his unit due to becoming very forgetful. He began needing assistance with activities of daily living.

Dementia in prison

- Can be mistaken for behavioral problem
- Very routinized prison life
- Other people in person's living unit may help them compensate
- Need for more education for unit staff

Mr. R

- Transferred to Sage Unit
- Adjusts well
- Frequently has calls with his son
- Appoints his son, who is living in the community, to be his medical power of attorney

Advanced care planning in prisons

- Patients can make their own decisions about what care they do and do not receive – this includes becoming DNR/DNI and going on comfort care
- Patients can appoint a durable power of attorney for medical care
- Legal next of kin can be called on to make decisions
- The prison does NOT make decisions on behalf of patients

Mr. R

- Dementia worsens
- Calls with his son become less frequent
- Based on physician capacity evaluation, no longer able to make his own decisions about end of life care needs
- Discuss with the patient's son his wishes, and he opts to make him comfort care.

Mr. R

- Evaluated by Sage team - is he distressed by his dementia? Does he have additional mental health needs?
- Discussed with geri-psych team - no medications, continue to monitor closely

Mr. R

- Mr. R reached the end of his sentence while on comfort care
- Sage team and social workers spoke with patient's son who wanted his father to live near him but could not meet his care needs at home
- Social work team worked to identify an Adult Family Home and primary care physician in the community

Release planning for older adults

- Variable amount of family involvement
- Many need adult family home placement
  - Some options for higher daily rate
  - Use of personal assets
- Placement challenges
  - Estimated vs Planned Release Date
- Prison needs to approve placement location

Take home points

Carceral settings are where much of US mental care is provided

There is a growing aging population in prison

Practical tip: People in prison can make their own medical decisions if they have capacity

References