The Practice of Electroconvulsive Therapy in US Correctional Facilities

A Nationwide Survey

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Objectives: There are little data regarding the practice of electroconvulsive therapy (ECT) in correctional settings in the United States. A survey was conducted to study the current practice of ECT in US prisons. We hypothesize that ECT is underutilized in the correctional setting. We also review the ethical aspects of using ECT for the treatment of mental illness in the prison population.

Methods: A 12-question survey via a SurveyMonkey link was emailed to chiefs of psychiatry, or the equivalent, of each state's department of corrections. We examined the frequency of Likert-type responses, tabulated individual comments for qualitative review, and grouped for comparison.

Results: Email contacts for chiefs of psychiatry, or the equivalent, for the department of corrections in 45 states (90%) were obtained and a survey link was sent. Thirty-one (68.9%) of 45 responded to the survey. Respondent estimates of the number of inmates with mental illness in 31 prison systems varied from less than 500 to more than 4500. Of these 31, 12 (38.7%) had more than 4500 inmates with mental illness. Four systems reported the use of ECT within the last 5 years. Of those, one reported use in the last 1 to 2 years, and 3 reported use in the last 2 to 5 years. Of these 4 prison systems, all felt that they had up to 10 patients who would benefit if ECT continued to be offered or became available in the future. None of these systems provided ECT within the prison. The inmates were referred to a local state psychiatric facility, a university hospital, or other institutions. The reasons for not using ECT as reported by the respondents are grouped under subheadings of stigma, ethical concerns, logistical concerns, and others.

Conclusions: Considering the high prevalence of mental illness in prisons, one might expect a high prevalence of ECT responsive mental illness and, hence, provision of ECT to some prisoners with mental illness. However, our survey suggests that the use of ECT in prisoners in the United States is low. Stigma, ethical concerns, and logistical concerns were the main hindrances for providing ECT to prisoners with mental illness. Given that ECT is the standard of care in certain clinical scenarios, physicians are obligated to offer such treatment to inmates when necessary. It can be argued that failure of the prison to offer the standard of care is unethical and unconstitutional.

Key Words: electroconvulsive therapy, ECT, inmate, prison, corrections, ethics

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Given the above, it seems evident that there are inmates who would benefit from ECT. Both a legal and ethical argument can be made that ECT should be available to inmates, given its effectiveness in treatment-resistant mental illness and the high mortality rate associated with mental illness. As per the US Supreme Court case, Estelle v. Gamble, “deliberate indifference by prison personnel to a prisoner’s serious illness or injury constitutes cruel and unusual punishment contravening the Eighth Amendment.”

Given that there are very little data regarding the practice of ECT in correctional settings in the United States, we conducted a survey to study the current ECT practice in US prisons. We hypothesize that ECT is underutilized in the correctional setting. We will also review the ethical aspects of ECT in the prison population.

METHODS

Each state’s department of corrections (DOC) was phoned to obtain email addresses for their chiefs of psychiatry or the equivalent. Each designated individual was emailed a 12-question survey via a Survey Monkey link. A copy of the survey can be obtained from the authors by request. The survey was sent in the following 3 waves: August, November, and December of 2014. During the second and final attempt, the surveys were sent to only individuals who did not respond to the previous wave. We examined the frequency of Likert-type responses, tabulated individual comments for qualitative review, and grouped for comparison. The study was approved by the Georgia Regents University Institutional Review Board.

RESULTS

Email contacts for chiefs of psychiatry or the equivalent for the DOC in 45 states (90%) were obtained. The contact information for the remaining 5 states (10%) was unavailable because the position was unoccupied at the time of the survey, because we could not reach the personnel who could provide us the contact information or because the state DOC refused to provide the contact information. The survey was completed by an official from 31 (68.9%) of 45 prison systems. Thirteen (41.9%) of 31 respondents identified themselves as chiefs of psychiatry, 3 (9.7%) of 31 as chiefs of behavioral health, and 15 (48.4%) of 31 as “other.”

In the other category, the respondents identified themselves as director/chief of mental health services, medical director, mental health administrator, vice president of correctional healthcare, or a general psychiatrist assigned to a mental health unit for inmates.

Respondent estimates of the number of inmates with mental illness in 31 prison systems varied from less than 500 to more than 4500. Of these 31 prison systems, 12 (38.7%) had more than 4500 inmates with mental illness (Fig. 1). Four systems reported the use of ECT within the last 5 years. Of those, one reported use in the last 1 to 6 months and three reported use in the last 2 to 5 years. Of these 4 prison systems, all felt that they had 1 to 10 patients who would benefit if ECT continued to be offered or became available in the future. Results from 1 question about the current use were not able to be interpreted because of inconsistencies in answers to this question. None of the 4 systems providing ECT had the facilities to perform the procedure within the prison. The inmates who received ECT were referred to a local state psychiatric facility, a university hospital, or other institutions for this service.

The respondents were given the option to comment if ECT was not being used in their respective state prison systems. Twenty-one of 31 respondents answered this question. The reasons for not using ECT are categorized below.

1. Stigma
   a. “Electroconvulsive therapy with an incarcerated patient population will be viewed as an inherently coercive and toxic treatment intervention.”
   b. “Anticipated resistance by patient and family.”
   c. “Anticipated resistance and stigma issues by media, legislative, and advocacy groups.”
   d. “Stigma more than anything else. We would be very open to hearing of its efficacy in this population and having guidance on policy development.”

2. Ethical concerns
   a. “Informed consent concerns.”
   b. “Right to treatment or right to refuse treatment arguments.”
   c. “Legal concerns such as surrogates or substituted judgment.”
   d. “Risk management fears such as possible litigation from ECT side effects.”

FIGURE 1. Diagrammatic representation of survey data.
3. Logistical concerns
a. “Obstacles in overcoming real world fiscal, contractual (eg, establishing and maintaining financial agreements) partnerships with university or private ECT treatment centers.”

b. “Logistical problems such as managing offender transport off-site and correctional officer escorts.”

c. “Lack of availability of ECT”

d. “Logistics, liability, and expense cited as the reason to not include the treatment within available modalities.”

e. “Electroconvulsive therapy providers unwilling to take on ECT with individuals serving time in prison.”

f. “Special permissions and consultations required but can be done.”

4. Others
a. “Insufficient number of prisoners with acute or severe mental illness with severe depression or psychosis requiring ECT to date.”

b. “Amount of cases are so few that the investment in space, personnel, and time would not be worth it.”

c. “Psychiatrists do not ascribe to ECT as an effective treatment.”

d. “Field staff has not requested or suggested ECT; patients have responded to medication treatment.”

DISCUSSION

It has been estimated that nearly 100,000 Americans receive ECT annually.13 Unfortunately, there is lack of data on the provision of ECT for inmates. Although inmates and forensic psychiatric hospital patients are not the same, there are some similarities. In a study from Germany, the indications for ECT in general psychiatric hospital patients and in forensic psychiatric hospital patients in 2005 are compared. Electroconvulsive therapy was indicated for ECT in 27 (3.5%) of 774 patients in the general psychiatric hospital, which would be comparable with 10 (3.2%) of 310 patients in the forensic psychiatric hospital. However, ECT was rarely applied to patients in the forensic psychiatric hospital. This was done for reasons similar to those discussed in the results section. All of the patients at the forensic psychiatric hospital carried a diagnosis of depression or schizophrenia spectrum disorder.16

Considering the high prevalence of severe mental illness in inmates, one might hypothesize that there would be a high prevalence of inmates for whom ECT is indicated. If that hypothesis is true, this survey seems to suggest that ECT is underutilized in the prison systems; only 4 of 29 state prison systems reported the use of ECT in the last 5 years. The respondents from these 4 prison systems felt that they had up to 10 patients who would benefit if ECT were offered in the future or continued to be offered. One of the limitations of this survey is that 25 of 31 respondents did not have a choice to answer a question about how many inmates might be appropriately referred for consideration of ECT; if it was available for inmates. This makes it difficult to assess the actual need for ECT in these prison systems. Nevertheless, the view that there is an insufficient number of prisoners with a diagnosis for which ECT is indicated is surprising and not entirely convincing. Comments such as, “Psychiatrists do not ascribe to ECT as an effective treatment,” are also quite surprising to read. Given the overwhelming evidence regarding the efficacy of ECT and its identification, as a standard of care for specific mental illnesses, this is difficult to fathom.5

The respondents’ comments seem to suggest that the stigma of ECT, ethical questions regarding ECT in inmates, and the logistics involved with ECT are the main hindrances to its use. Stigma associated with mental illness in general and with ECT in particular is a long-standing barrier to research and treatment.17,18 Stigma or anticipated rejection of therapy does not justify a failure to offer standard of care treatment to patients. It generates an obligation to attempt to educate staff, patients, and their families regarding appropriate treatment modalities. The ethical physician would not adopt the position that “We know there is a lot of stigma about ostomy bags, so we will not offer a permanent colostomy to patients who need large sections of their colon removed.” Similarly, the physician should not adopt such a position with ECT.

It is unethical and unconstitutional to deny the standard of care for inmates with mental illness. The ethical and legal obligation to provide healthcare to inmates is well recognized.19 The United Nations has specified the obligation in terms of the principle of equivalence: “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”20 In Estelle v. Gamble, the US Supreme Court recognized the right of persons in prison or jail to healthcare.14 Confinement prevents access to care such that failure to provide care constitutes cruel and unusual punishment and violates the Eighth Amendment of the US Constitution. To fulfill inmates’ recognized right to receive standard of care treatment, the resources and discretion necessary to provide appropriate healthcare must be made available to healthcare professionals.21 Therefore, prisons have an ethical and legal obligation to provide access to ECT for patients in whom it is indicated as the standard of care.

Lack of access to ECT, when it is indicated as standard of care, raises concerns that inmates are being treated unjustly because they face discrimination due to their legal status. Because the inmate population disproportionately consists of people of color, additional concerns about justice and discrimination are relevant. In addition, a protocol referring inmates to outside resources for ECT seems to be the simplest way to address the hindrances involved in administering it to inmates.

Providing ECT to inmates requires special attention to common ethical obligations of physicians, such as obtaining free and voluntary informed consent and protecting privacy and confidentiality.22 Satisfying these requirements, in the care of prisoners, may pose special challenges and require additional effort. Mechanisms to improve informed consent among patients with mental illness are well documented.23 To the extent that surrogate decision makers are permitted to give consent for treatment when a patient lacks decisional capacity, surrogates should be properly informed. There is evidence that when provided with the necessary information, a majority of surrogates can make a decision regarding ECT treatment comparable with what the patient would decide, if able to do so.24 These interventions can be used to address some of the ethical concerns associated with ECT decisions. Concerns about the voluntariness of inmates’ consent apply to all treatments and research. They may be assuaged by the fact that prisoners report feeling coerced to participate in research very infrequently. This suggests that it is possible to obtain voluntary informed consent in this population.25 In addition, providing ECT to inmates requires attention to ethical issues unique to the corrections setting. Healthcare professionals working in corrections settings have obligations to their patients but also are serving the prison system, raising the possibility of conflicting obligations or goals.21 This circumstance may compromise the trust that patients (inmates) have in physicians, a concern given the importance of trust in professionals for the therapeutic alliance.21 If ECT is indicated for inmate patients, then there is an obligation to establish protocols that facilitate providing the standard of care ethically, as is required for any other treatment modality.
In light of the obligation to provide inmates with treatment that meets the standard of care, a number of the logistical issues raised as reasons for not offering ECT should be resolved to remove barriers to treatment. From the financial stand point, investment in space for an ECT suite and personnel in the prison may not be feasible. No respondents in this survey replied that their prison system is currently equipped with an ECT suite. Those few prisons currently providing ECT arranged the treatment for inmates with a local state psychiatric hospital, a university hospital, or other private institutions. This may be a more cost-effective alternative. Transportation requirements, the processing of special permissions requests, and other operational issues can be resolved much as they are for any other inmate requiring treatment outside the correctional facility.

One area for further research would be the role that ECT might play in treating inmates in administrative segregation with mental illness. Solitary confinement in US prisons is a growing problem with a reported 17% increase from 2008 to 2013. Solitary confinement is generally reserved for incorrigibly violent and dangerous people. Violent and dangerous behavior can sometimes be a clinical presentation in patients with treatment-resistant mania and psychosis (for which ECT is indicated). Effective treatment of inmates with this clinical presentation would relieve unnecessary suffering from both solitary confinement and mental illness. Thus, it would seem even more ethically and constitutionally imperative to give these patients a trial of ECT.

In addition to the aforementioned ethical and constitutional imperatives, prisons might also realize significant cost savings (on a few fronts) by giving ECT to those administrative segregated inmates with mental illness for whom it is indicated. Firstly, if the clinical presentation of violent and dangerous behavior resolved with the effective treatment of the mania or psychosis, costly administrative segregation is no longer needed. Secondly, if the violent and dangerous behavior did resolve, the patient may now be appropriate for effective behavioral treatments that their treatment-resistant mania or psychosis previously prevented them from attending, due to an inability to appropriately cognitively process the material taught in these therapies. When effective, this behavioral therapy can lead to a transfer to general population. In this second situation, cost savings occur on 2 fronts. The effective treatments have been shown to not only remove the patient from costly administrative segregation but also to decrease the rate of recidivism.

CONCLUSIONS

The prevalence of mental illness is high in the inmate population, but the prevalence of inmate mental illness that is responsive to ECT is unknown. This survey did not measure the rate of inmates with an ECT responsive illness. However, we can legitimately hypothesize that the ECT responsive illness will likely be high in a population that has a higher prevalence of mental illness and suicide. Despite this, only 4 respondents of the survey reported the use of ECT in the last 5 years. In addition, no respondent replied that their prison system is equipped with an ECT suite. Inmate ECT treatment occurred at a local state psychiatric hospital, a university hospital, or other private institutions.

Electroconvulsive therapy is the standard of care for certain clinical scenarios. In some instances, it is critical to recovery. It is also theorized that it may potentially decrease the need for administrative segregation in certain patients. Given this, physicians are obligated to offer such treatment to inmates when needed. It seems that a lack of education about the standard of care, stigma, ethical concerns, and logistical concerns has prevented the implementation of ECT use in correctional facilities. These issues need to be addressed. Instituting specialty service contracts with outside providers for ECT, as is done when medical subspecialty services are required, seems to be a viable solution. It can be argued that failure of a correctional facility to offer this standard of care treatment might be unethical and, some might even argue, unconstitutional.

REFERENCES


