If It Were Physical Pain, It Would Be Called Torture: A Story of Two Young Men

by Douglas A. Kramer, MD, MS

When did human rights become negotiable in the US? When did human rights become a line item in a budget in the US? When did it become so difficult to simply do the right thing? Two recent newspaper articles portray how the seriously mentally ill have been systematically stripped of their human rights. By "human rights," I mean the right to life and liberty.

The senator and his son

On November 1, 2014, *The Washington Post* ran an update on Virginia State Senator and former gubernatorial candidate, Creigh Deeds. One year earlier, his 24-year-old son almost killed him—before killing himself. In "A father's scars: for Va's Creigh Deeds, tragedy brings unending questions," Stephanie McCrummen[1] tells the story of what life is like now for the senator.

> He gets out of bed, where a piece of the shotgun he had taken apart in those last days of his son's life is still hidden under the mattress. He goes outside to feed the animals, first the chickens in the yard and then the horses in the red-sided barn. He leads the blind thoroughbred outside with a bucket of feed, the same bucket he was holding when he saw Gus walking toward him—"Morning, Bud," he said; "Morning," Gus said, and began stabbing him—and then he goes back inside.

The dismantling and closure of the federal and state mental hospitals beginning in 1955 has resulted in an extreme shortage of programs and facilities for troubled persons such as Austin "Gus" Creeds to be evaluated; treated as long as necessary, ideally to a reasonable assurance of long-term stability; or kept indefinitely if necessary.[2,3] That patients in some state mental hospitals were poorly treated, mistreated, or maltreated in the past does not mandate that a new public mental hospital system would do so.

Opponents of reinvigorating the public mental hospital system argue for community programs. However, community programs are always vulnerable to state and local budget cuts; have not been demonstrated to be consistently effective at early identification and management of young persons with emerging psychoses, especially if no crimes have been committed; and cannot ensure the safety of persons such as Gus Creeds and their potential victims—the victims often being people they love. Community programs are important but serve a different purpose in the continuum of care for the severely mentally ill.

The college student and the county jail

The second article addresses where many of the seriously mentally ill are now found—if they have committed a crime: in our county jails, or for more serious crimes, in our state prisons. *The Capital Times*, a Madison, Wisconsin, weekly, published the following description of how life can be for the seriously mentally ill in a county jail—that life often being in solitary confinement.[4]

In, "Boxed in: fighting for changes," Sheriff Dave Mahoney calls his own jail "inhumane." Steven Elbow describes the 4-day experience in solitary of Ian Olson, a 21-year-old college student at Macalester College. Ian was arrested for disorderly conduct after being disruptive and uncontrollable at a family gathering. This manic episode occurred because he had not taken his medication for bipolar disorder. It was the first time this had happened in 2 years of treatment. Judging from the date of his arrest, I am guessing that he discontinued his medications while studying for finals, or in conjunction with the end of his spring semester. This description of life in solitary confinement while psychotic is typical:

> But he admits that on May 10, 2013, he was disruptive, insolent and uncontrollable, so much so that when he was taken to the jail, deputies abandoned the booking process and put him into Segregation Cell 1, a stark 6-by-9 foot room with a concrete bed, a thin green mattress, a steel toilet and sink, and a metal door with a small slot for food. The overhead light remained on 24 hours a day. On his first day, he flooded his cell by clogging the toilet, was placed in a "suicide smock," and later strapped by the torso, ankles and wrists to a "violent prisoner restraint chair." He didn't eat, his water supply was cut off and he slept only sporadically.

Two different outcomes—both disturbing

The main difference between Ian Olson (college student) and Gus Deeds (senator's son) is that Mr Olson had committed a crime, while Mr Deeds had not. Mr Olson lived, but endured 4 days of "inhumane treatment," a euphemism for "torture." This was caused by roadblocks for immediately admitting such patients to the barely functioning nearby state mental hospital. Such roadblocks are economically driven.

Mr Deeds died because of the same roadblocks. Time had run out on a court order remanding him to treatment at a state psychiatric hospital. There were no beds available at the time the order was obtained, and the legal limit in 2013 for holding someone while awaiting a bed, presumably someone dangerous to themselves or others, in North Carolina, was 6 hours. There are civil liberties reasons for limiting the length of psychiatric holds. However, dangerousness should trump civil liberties—especially when the currency is measured in hours—and psychosis

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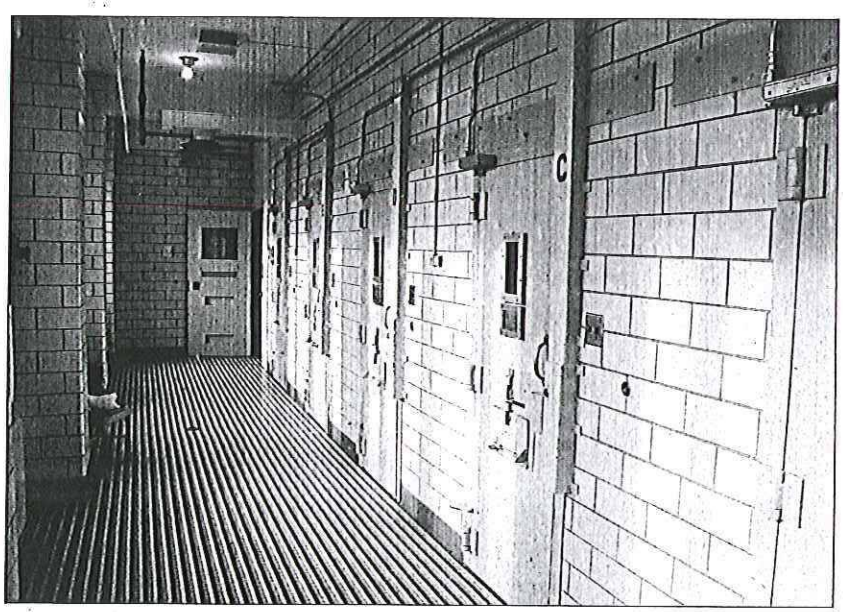

A Story of Two Young Men

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with dangerousness is neither life nor liberty and is measured in lifetimes. If Mr Deeds had committed a crime, perhaps he could have gone to solitary confinement at the county jail—experienced inhumane treatment there—and lived.

Inhumane treatment of the mentally ill—is this really who we are?

Sheriff Dave Mahoney in Wisconsin belongs in the same discussion as Dorothea Dix, a serious reformer who campaigned for the treatment of the seriously mentally ill in hospitals rather than have them languish in jails and prisons—often in solitary confinement—sometimes for years, occasionally for decades.[3] The article referenced in *The Capital Times* includes a 2-minute video of Sheriff Mahoney, standing in one of the solitary confinement cells at the Dane County Jail, as he explains why we need to change the current system.[4]

For every young adult from a socially and economically advantaged family, presumably capable of finding appropriate services, like the Deeds and Olson families appear to be, how many dozens, or hundreds, or perhaps thousands of such patients from disadvantaged families are being subjected to similar treatment and worse? Or living under a bridge suppressing their psychological pain with drugs and alcohol?

Real leaders do not compromise with right and wrong. Such leaders do not delay when "inhumane treatment" is occurring. Leaders educate constituents and advocate for justice. Leaders do the right thing oblivious to the electoral calculus. Leaders do not consider "inhumane treatment" to be a line item in a budget. A reinvigorated public mental hospital system would save the lives of people like Gus Creeds and the daily pain his parents still experience, as well as obviate the need to use solitary confinement for people like Ian Olson. Everyone has the right to life and liberty.[5]

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Moving Beyond "Hand Waving": Why Do People Sleep a Lot After a Traumatic Brain Injury?

by Barbara Schildkrout, MD

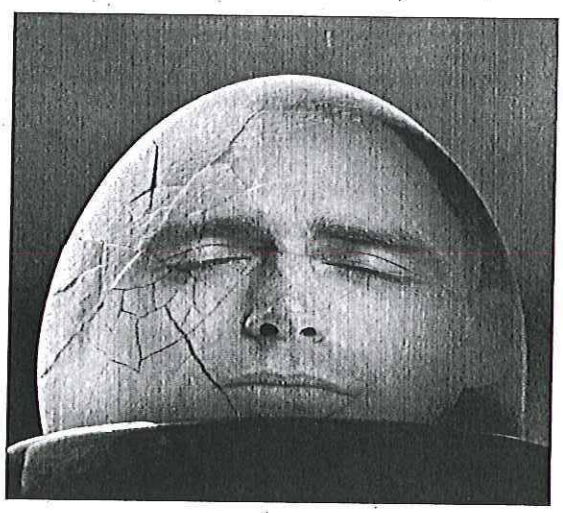
Your patient is recovering from a traumatic brain injury (TBI). He asks you, "Doc, why do I need so much extra sleep? And, what makes me so sleepy during the day?"

If you're like me, you've told patients like this individual that it takes time for the brain to heal. You've explained that even a mild concussion can disrupt neural fibers and that mental activity may be more effortful following such an injury.

Perhaps there is some truth to all of that. But probably it is mostly "hand waving."

I just read about what is more likely to be the actual explanation for those post-TBI symptoms. The *Annals of Neurology*[1] published research showing that in severe TBI, there is substantial loss to specific types of neurons in the hypothalamus—namely neurons that are part of networks involved in promoting wakefulness or in regulating sleep.

The potential explanatory power of these findings is impressive. Although this research was conducted in cases of fatal brain trauma, nonetheless it provides insights that will help scientific investigators and clinicians think more specifically about disruptions in sleep and wakefulness following any traumatic brain injury.



TBI and sleepiness

TBIs are a major public health concern, affecting close to 2.5 million individuals each year in the US, according to the CDC statistics for 2010.[2] Whether the TBI is mild or severe, at least 25% of patients experience some disturbance in sleep and/or level of daytime arousal following the injury. Symptoms in this arena may substantially affect recovery and contribute to disability.

Every psychiatrist has encountered patients who have had TBIs—from mild concussions as a consequence of collisions on the soccer field or falls on icy steps to devastating brain injuries after motor vehicle accidents or barroom fights. These post-TBI patients frequently experience excessive daytime sleepiness in the face of what used to be sufficient sleep time. They also commonly exhibit pleiosomnia—the need for more than the usual amount of sleep in a 24-hour period. Less frequently, patients have disturbed nighttime sleep—insomnia.

Effective approaches are needed to help patients with these post-TBI difficulties. The design of new treatment strategies depends on developing a better understanding of the mechanisms that underlie these post-TBI problems with arousal and sleep.