Incarcerated individuals with severe mental illness generally receive insufficient treatment.

Suicide rates among incarcerated individuals with mental illness are six times higher than in the general population (Galanek et al., 2014).

Though legislation requires people in custody to receive adequate health care, standards for "adequate care" are largely driven by litigation (e.g., Estelle v. Gamble) rather than by correctional facilities' attempting to develop best practices (Canada et al., 2022).

The question of whether a mentally ill offender should be treated in a psychiatric hospital or in prison remains politically controversial, and access is limited. However, individuals with psychotic illness therefore require removal to hospital treatment because of life-threatening self-harm, risk of violence, or victimization of other prisoners (Konrad et al., 2012).

Incarcerated individuals thus face either long waitlists at local psychiatric hospitals and/or repeated hospitalizations for symptoms that could have been avoided if there were stable, consistent, and adequate mental health care available in prisons.

Deinstitutionalization and reduction in the number of psychiatric inpatient beds have contributed to this mental health crisis in the U.S. criminal justice system (Gao et al., 2021).

This case shows how delayed identification and mismanagement of a mental health crisis greatly impeded medical and psychiatric care of a prisoner with catatonic schizophrenia, highlighting the flaws in the health care system for incarcerated individuals.

Substandard care within prison, inadequate attribution of symptoms and correctional interference with and failure to continue appropriate care provided at outside hospitals greatly worsened this patient's condition. Accreditation of prison health care is optional and is poorly regulated (Canada et al., 2022); therefore, both understanding of and ability to continue hospitals' care plans may be lacking, as in our case. Since correctional officers are essentially gatekeepers to care, prisoners with impaired communication or capacity are at particular risk. An account by an incarcerated individual highlights this:

"... you gotta fill out the sick slip and give it to the guard maybe and maybe he'll put in the sick box, and they get it later or whenever they decide to pick it up" (Canada et al., 2022)

Our patient endured five weeks of what was deemed a "hunger strike," as well as a subarachnoid hemorrhage, and a two week period in correctional psychiatric unit addressed neither condition properly. A study examining an accountability model implemented between correctional officers and incarcerated individuals demonstrates the importance of this therapeutic alliance:

"If they really don't know you, or think you're playin' [manipulating], they'll tell you to write a kite. If the officer likes you, and you're for real with them [officers], they'd do you a favor, they'll help you. There's trust there. (Galanek et al, 2014)

Currently, correctional health care providers, facilities, and staff are unprepared for complex, severe medical and psychiatric illnesses. Without adequate regulation or standards for expertise and treatment facilities, there is no mechanism to ensure quality care psychiatric care for the incarcerated SMI population. Barring regulatory changes, the burden falls to outside hospitals that treat more complex medical conditions. The findings from this case demonstrate the importance of the therapeutic alliance between correctional officers and incarcerated individuals to provide quality care to this vulnerable population.