REGULAR ARTICLE

Jail Hospitalization of Prearraignment Patient Arrestees with Mental Illness

Susan M. Gray, MD, Christopher W. Racine, MD, MPH, Christopher W. Smith, PhD, and Elizabeth B. Ford, MD

A growing number of individuals with mental illness are receiving psychiatric treatment in the criminal justice system. However, mental health problems facing individuals immediately after arrest and before arraignment have not been adequately studied. In New York City, prearraignment arrestees who require psychiatric hospitalization are temporarily transferred from police custody to correctional custody and admitted to the Bellevue Jail Psychiatry Service (BJPS) for treatment. The purpose of this study was to gain a better understanding of the impact of this jail hospitalization on the legal disposition of this vulnerable population. A retrospective chart review was conducted of 204 consecutively admitted male patient-arrestees on the BJPS. Results showed that admission to the BJPS delayed arraignment by an average of 8.03 days, with longer delays for individuals arrested outside of Manhattan. Although these delays are considered acceptable under legal precedent, concerns arise about the therapeutic impact of this practice on newly arrested individuals with severe mental illness.

J Am Acad Psychiatry Law 42:75–80, 2014

A growing number of individuals with mental illness are receiving psychiatric treatment in the criminal justice system.[1,2] This situation has prompted increased emphasis in recent decades on mental health care provision in jails and prisons, reentry into the community, and alternatives to incarceration through problem-solving courts. In addition, the jail environment has been found to be conducive to suicidal behavior,[3] with suicide rates in jails approximately four times higher (47/100,000 inmates) than in the community.[4] Although we continue to learn more about psychiatric concerns for individuals in jails and prisons, we know little about those arrested who have mental illness and have not yet reached jail (i.e., those who have not been arraigned).

The time between arrest and arraignment (time to arraignment) can be very stressful. According to a study of 281 adults awaiting arraignment in Brooklyn, New York, "participants described past and current arrest experiences as activating previous trauma and exacerbating symptoms" (Ref. 5, p 675). Arraignment, although typically a relatively short proceeding and not requiring much more on the part of the accused than to be present and to communicate, is a critical juncture in an individual's path through the criminal justice system. Criminal charges are read for the first time, a detainee is advised of his rights, a plea is entered, legal counsel is assigned if not already retained, a competency examination may be ordered for the first time, and most important, the first opportunity for release from custody is presented. Release may come in a variety of forms, including outright dismissal of charges, a guilty plea, sentence and release with time served, and the establishment of and the opportunity to pay bail. As noted by Justice Murphy in an appellate decision for various *habeas corpus* petitions involving arraignment delays in Manhattan, "the deprivation entailed by prearraignment detention is very great with the potential to cause serious and lasting personal and economic

Dr. Gray is Clinical Instructor, Department of Psychiatry, NYU School of Medicine, and Attending Psychiatrist, Division of Forensic Psychiatry, Bellevue Hospital Center, New York, NY. Dr. Racine is Chief Resident in General Psychiatry, Department of Psychiatry, NYU School of Medicine, New York, NY. Dr. Smith is Director of Adult Services, NYC Field Office, NYS Office of Mental Health, New York, NY. Dr. Ford is Clinical Associate Professor, Department of Psychiatry, NYU School of Medicine, and Director, Forensic Psychiatry, Bellevue Hospital Center, New York, NY. Presented under the title, "When rights collide: the right to a speedy arraignment vs. right to psychiatric care," as an oral presentation at the Annual Meeting of the American Academy of Forensic Sciences, Chicago, IL, February 25, 2011, and again as a poster at the 42nd Annual Meeting of the American Academy of Psychiatry and the Law, Boston, MA, October 29, 2011. The views expressed in this article do not necessarily reflect the official views of the New York University Department of Psychiatry, Bellevue Hospital Center, or the New York City Health and Hospitals Corporation. Address correspondence to: Elizabeth B. Ford, MD, Bellevue Hospital Center, 462 First Avenue, NBV 19W21, New York, NY 10016. E-mail: elizabeth.ford@nyumc.org.

Disclosures of financial or other potential conflicts of interest: None.

harm to the detainee. . . . It is, moreover, a deprivation frequently more severe than would be exacted from a defendant whose guilt has been proven."[6]

For individuals with mental illness, the time to arraignment can be even more destabilizing, as there may be limited access to psychiatric medication, abrupt loss of social and mental health supports, and a marked shift in daily routine. In New York City, the New York City Police Department (NYPD) and court system try to minimize the time to arraignment pursuant to Criminal Procedure Law (CPL) 140.20, which states that NYPD officers must present a detainee to the courts "without unnecessary delay."[7] The meaning of without unnecessary delay has not been statutorily defined, but a 1991 Court of Appeals decision in New York found that "a prearraignment detention [should] not be prolonged beyond a time reasonably necessary to accomplish the tasks required to bring an arrestee to arraignment," generally 24 hours unless an "acceptable explanation" is provided.[8]

The provision of urgent psychiatric care, including hospitalization, qualifies as an acceptable explanation for a time to arraignment exceeding 24 hours. Arrestees who are in need of psychiatric evaluation at any point from arrest to arraignment, as determined by the NYPD on the basis of behavior and dangerousness, are taken to a local emergency room or a comprehensive psychiatric emergency program (CPEP). Five to 10 percent of individuals brought to local CPEPs by the NYPD are evaluated by a psychiatrist as too ill to proceed in police custody to arraignment, generally meaning at very high risk of suicide or dangerously crippled by psychosis. The patient-arrestees are subsequently admitted, pursuant to civil commitment statutes, to the Bellevue Jail Psychiatry Service (BJPS) in Manhattan for men or Elmhurst Hospital in Queens for women. Both jail services are considered outposts of Rikers Island, New York City's local jail. Although Bellevue is situated in the borough of Manhattan and Elmhurst is in the borough of Queens, both facilities serve as the only jail psychiatry services for all five city boroughs (Bronx, Brooklyn, Manhattan, Queens, and Staten Island).

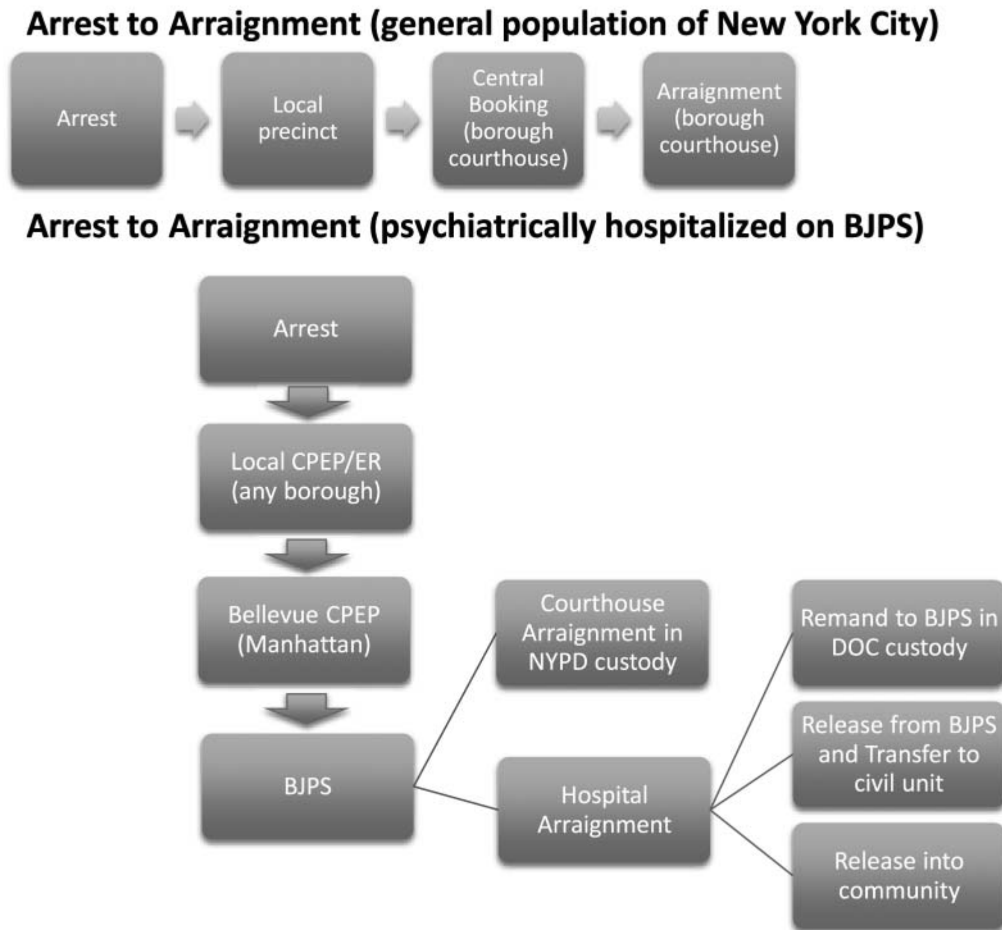
The BJPS is jointly operated by clinical staff at Bellevue Hospital and the New York City Department of Correction (DOC). Although the quality of psychiatric care on the BJPS is the same as that on the multiple civilian psychiatric units at Bellevue, the restrictions on phone calls, clothing, food, and possessions; the inability to move off the unit without being shackled; and the presence of DOC officers and gates on the units clearly differentiate the service as a jail.

A longstanding historical agreement between the DOC and the NYPD allows for male prearraignment arrestees who are in need of psychiatric hospitalization to be housed on the BJPS while they receive treatment and await arraignment. Arraignment occurs by one of three mechanisms: a standing weekly arraignment court at the hospital for patients arrested in Manhattan and occasionally the Bronx; rare video arraignments for patients arrested in any of the five boroughs, assuming cooperation with the local borough court and district attorney's office; and discharge from the jail psychiatry service to NYPD custody for arraignment at the courthouse, once the patient-arrestee is clinically stable.

Approximately 55 percent of the prearraignment admissions to the BJPS are discharged to NYPD custody before arraignment. For the remaining 45 percent who receive a hospital arraignment because they cannot be safely transported out of the hospital to the courthouse, approximately one-third are released from custody and are immediately transferred to a Bellevue civilian psychiatric unit pursuant to involuntary civil commitment standards. The remaining two-thirds are remanded to DOC custody and remain on the BJPS. Only a handful of patient-arrestees per year are released from custody at arraignment and are considered stable enough to be discharged to the community (Fig. 1). Each patient-arrestee on the BJPS has concurrent and ongoing criminal and civil commitment procedures. A patient might be clinically discharged but kept in criminal custody or released from custody but kept civilly committed on a nonforensic inpatient psychiatric unit.

Although many jurisdictions in this country, including others in New York State, hospitalize prearraignment arrestees on civilian psychiatric units and then discharge them to police custody once they have stabilized, New York City uses the hospital jail psychiatry services to detain and treat this population before arraignment.[9]

A literature search of the major medical and legal search engines using the keywords mental illness, prearraignment, arraignment, arrest, criminal justice, and arrestee revealed very few articles characterizing the prearraignment population and none



CPEP (Comprehensive Psychiatric Emergency Program); ER (Emergency Room); BJPS (Bellevue Jail Psychiatry Service); NYPD (New York City Police Department); DOC (New York Department of Correction).

Figure 1. Pathway of arrest to arraignment for the general population versus hospitalized arrestees in New York City.

focusing specifically on length of prearraignment detention for individuals receiving medical or psychiatric care on an inpatient hospital service. As the patient-arrestees admitted to the BJPS are assumed to have a longer time to arraignment because of their acute psychiatric needs, we sought a better understanding of the implications of such a practice in terms of optimizing psychiatric treatment opportunities and minimizing any unnecessary exposure of the severely mentally ill to the potentially destabilizing environment of jail.

Method

The study population consisted of all male patient-arrestees consecutively admitted to the BJPS between February 1, 2010, and March 31, 2011 ($n = 204$). Subjects were identified from a database of admissions maintained by the Division of Forensic Psychiatry at Bellevue Hospital. A retrospective chart review of each subject's electronic medical record was conducted. Demographic, clinical, and legal variables were collected, including borough of arrest, top criminal charge, date of admission to the CPEP, and date of arraignment. The date of admission to the CPEP was used as a proxy for the date of arrest because of limited access to criminal justice records and because most NYPD arrestee presentations to the CPEP occur within hours of arrest and before the arrestee is processed at the local precinct. Subjects were excluded if their arraignment date could not be identified ($n = 21$), yielding a final study sample of 183 subjects. The primary outcome variable was the time in days until each patient-arrestee was arraigned. The study was approved by the Institutional Review Boards for NYU School of Medicine and Bellevue Hospital Center.

Table 1 Demographic Characteristics of Patient-Arrestees

	n	%	Time to Arraignment (days)	Statistic	*p*
Age				*F* = 1.327	.262
18–30	64	35	7.59		
31–40	42	23	9.55		
41–50	52	28.4	7.77		
51–60	19	10.4	6.58		
61+	6	3.3	9.00		
Race/ethnicity				*F* = 0.331	.857
Black	84	45.9	7.76		
Hispanic	43	23.5	7.92		
White	41	22.4	8.20		
Asian	11	6	9.27		
Other	4	2.2	10.0		
Discharge diagnosis				*t* = 1.842	<.0004 (psychotic vs. not)
Psychosis	109		8.6		
Schizophrenia	47	25.7			
Schizoaffective	24	13.1			
Psychosis NOS	26	14.2			
Bipolar I with psychosis	19	10.4			
No psychosis	74		7.19		
Affective	25	13.7			
Substance	23	12.6			
Adjustment disorder	24	13.1			
Malingering	2	1.1			
Top criminal charge				*t* = 2.170	<.022
Misdemeanor	107	58.5	7.28		
Felony	75	41	9.18		
Borough of arrest				*t* = −4.610	<.000 Manhattan vs. all others
Manhattan	97	53	6.4		
Brooklyn	41	22.4	10.66		
Queens	20	10.9	11.05		
Bronx	16	8.7	8.30		
Staten Island	7	3.8	7.0		

SPSS (v. 19.0) was used for analyses. The impact of each of the collected variables on time to arraignment was examined by subdividing the sample and conducting t tests or analyses of variance (ANOVA) depending on the number of subgroups. A *post hoc* survival analysis was conducted for better characterization of the impact of geography (i.e., the borough of arrest) on time to arraignment.

Results

Data on 183 subjects were available for analysis. The mean time to arraignment for all subjects was 8.03 days. Demographic, clinical, and legal characteristics of the sample were recorded and are shown in Table 1. An ANOVA was used to test whether any of the variables had a significant impact on time to arraignment. Neither age nor race was significantly related to time to arraignment ($F = 1.327$, $p = .26$, and $F = .331$, $p = .86$, respectively). Subjects with a psychotic disorder had a significantly longer time to arraignment than those without a psychotic disorder (8.6 days versus 7.2 days, respectively; $t = 1.842$; $p = .004$). Subjects facing an initial felony charge were arraigned significantly later than those facing a misdemeanor charge (9.2 days versus 7.3 days, $t = 2.170$, $p = .022$.)

The mean time to arraignment for subjects arrested in Manhattan was compared with that of those arrested in the other boroughs. Subjects in Manhattan had a significantly shorter time to arraignment (6.4 days) than did those from the other four boroughs (10.07 days) ($t = -4.610$; $p < .0005$). Survival analysis shows that all subjects from Manhattan were arraigned within 20 days; all subjects from the other boroughs were arraigned within 41 days (Fig. 2).

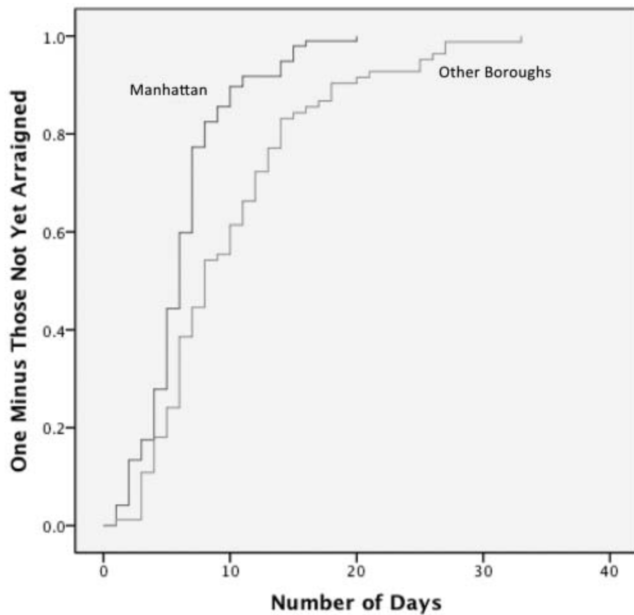


Figure 2. Kaplan-Meier survival curve: days to arraignment for Manhattan versus other boroughs.

Discussion

Our results indicate that prearraignment patient-arrestees who were given a psychiatric commitment on the BJPS waited, on average, eight days to be arraigned. Those in the outer boroughs waited even longer. Even if this delay is considered necessary and is not a violation of constitutional rights, it is clearly longer than the average time to arraignment for individuals in the community. A study published in 2006 by the New York Civil Liberties Union found that 87.6 percent of NYC arrestees were arraigned between 24 and 36 hours, 11.5 percent were arraigned between 36 and 48 hours, and fewer than 1 percent were arraigned after more than 48 hours.[10]

Our concerns about these results are shaped by an understanding that, although the BJPS seeks to provide high-quality psychiatric care, a jail setting is not considered optimal for mental health recovery. Patient-arrestees are restricted in the number and type of phone calls they can make, the kind of food that they can consume, the type of clothing they can wear (e.g., no jeans, no gang colors, and no clothing that resembles clinical or correctional staff uniforms), and the access to efficient discharge planning services in the community, since many programs require a known or actual release date from custody before applications will be accepted. Patients on the jail service do not have access to interaction with females other than staff, undergo daily and random room and person searches, and are shackled on their wrists and ankles when they are moved off the unit for any reason, including for clinical purposes such as radiology tests. There are also higher rates of patient-patient violence on the BJPS compared with those on Bellevue civilian psychiatric units, making it a riskier service on which to be hospitalized. Perhaps even more significantly, patients are watched day and night by correction officers who, however benevolent they may be, serve as constant reminders that the unit is a jail. We argue that none of these procedures is therapeutic for a mentally ill population and that they are often countertherapeutic. The effect is particularly true in those in our study sample, 57.9 percent of whom had a primary non-substance-related psychotic disorder and all but two of whom had a primary Axis I diagnosis.

The geographic differences found in the study are also notable. Patients arrested in Manhattan had shorter times to arraignment than those arrested in the Bronx and significantly shorter times to arraignment than those arrested in Brooklyn, Queens, or Staten Island. This discrepancy is most likely explained by the closure in 2004 of the jail psychiatry service at Kings County Hospital in Brooklyn, analogous to the jail service at Bellevue. We do not have data regarding time to arraignment for patient-arrestees before 2004, but it is likely that an available treatment facility in Brooklyn reduced the travel and administrative barriers to arraignment that must now be overcome in the outer boroughs.

Our finding that individuals with psychotic disorders had a longer time to arraignment than those without psychotic disorders was anticipated. The psychotic population tends to be less stable and therefore less able to be discharged quickly to police custody to proceed to arraignment. Experience also indicates that there tend to be longer administrative delays in processing psychotic individuals for arraignment because of refusal to be fingerprinted, incomplete or inaccurate identifying information, or both.

We had an unexpected finding that will require further exploration. Individuals initially charged with misdemeanor offenses had a significantly shorter time to arraignment than did those initially charged with felonies. There does not appear to be a clear legal explanation for the difference, as felonies and misdemeanors are processed and booked simi-

larly before arraignment. It is possible that clinicians on the BJPS feel more pressure to advocate for arraignment for their patients charged with misdemeanors because they are aware of the higher probability of release from custody, but this explanation is only speculation. Future projects are planned to help clarify this finding.

This study has limitations, many of which we hope to overcome in future analyses. Our results are specific to men with severe mental illness who were arrested in New York and hospitalized before arraignment. Although this does not represent a large number of individuals compared with all arrested individuals (338,214 in 2011),[11] it represents a population that is particularly vulnerable to the stresses involved in waiting for arraignment.

The date of admission to the Bellevue CPEP was used for the date of arrest, because of limited access to criminal justice databases. The use of this proxy resulted in an underestimate in the time to arraignment for our sample. All subjects presented to CPEP, either on the day of arrest or within several days after, but never before. Although the arrest dates would have been more precise, our findings would have been more significant, not less, with this information.

Future projects include a replication of this study with female patient-arrestees, identifying the arraignment outcomes for our study sample to assess better whether arraignment has a meaningful impact on custody status (i.e., what percentage of patient-arrestees are actually released from custody at arraignment) and comparing the times to arraignment and arraignment outcomes of arrestees admitted to the BJPS to those of arrestees who did not require psychiatric hospitalization.

The findings from this study demonstrate a previously undocumented interface between mental health and the criminal justice system that places arrestees needing psychiatric hospitalization on a jail service before arraignment. This process causes meaningful delays in facilitating arraignment, even if hospitalization is considered an acceptable explanation under the law. Severely mentally ill arrestees who require prearraignment psychiatric hospitalization are the only group of arrested individuals in New York City who are detained in jail before being arraigned. Arrestees who require prearraignment hospitalization on medical or surgical services are taken to civilian units, which, while guarded as correctional outposts, are not subject to the same restrictions as the jail psychiatry units.

As a result of this preliminary exploration, we are advocating for combined efforts on the part of the many city agencies tasked to care for this population to explore cost-effective and efficient mechanisms to arraign psychiatrically hospitalized arrestees. Examples of such mechanisms include greater access to video arraignments and a more streamlined in-hospital booking process. We would also like to advocate for more discussion about the somewhat unique practice of hospitalizing in a jail setting the mentally ill individuals who have not been formally charged with a crime.

References

1. Wilper AP, Woolhandler S, Boyd JW, *et al*: The health and health care of US prisoners: a nationwide survey. Am J Public Health 99:666–72, 2009
2. James DJ, Glaze LE: Mental health problems of prison and jail inmates. Washington, DC: Bureau of Justice Statistics, Special Report, U.S. Department of Justice, Office of Justice Programs, 2006
3. Bonner R: Correctional suicide prevention in the year 2000 and beyond. Suicide Life Threat Behav 30:370–6, 2000
4. Mumola CJ: Suicide and homicide in state prisons and local jails. Washington, DC: Bureau of Justice Statistics Special Report, NCJ 210036 2005, pp 1–12, 2005
5. Broner N, Lamon S, Mayrl DW, *et al*: Arrested adults awaiting arraignment: mental health, substance abuse, and criminal justice characteristics and needs. Fordham Urb L J 30:663–71, 2002
6. State ex rel. Maxian v. Brown, 561 N.Y.S.2d 418 (N.Y. App. Div. 1990)
7. N.Y. Crim. Proc. Law § 140.20 (McKinney 2010)
8. People ex rel. Maxian v. Brown, 77 N.Y. 2d 422 (N.Y. 1991)
9. Mack A, Alter C, Newman A: The interface of mental illness and the criminal justice system in the District of Columbia: analysis and recommendations: a report submitted to the Criminal Justice Coordinating Council, January 2007
10. Ofer U, Gonzalez Y, Perry R: Justice Delayed, Justice Denied: A Study of Arrest to Arraignment Times in New York City. New York: New York Civil Liberties Union, 2006
11. New York State Division of Criminal Justice Services: Adult arrestees 2002–2011. Available at http://www.criminaljustice.ny.gov/crimnet/ojsa/arrests/NewYorkCity.pdf. Accessed February 18, 2013