Introduction of a Psychiatric Acute Care Clinic into a Metropolitan Jail

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Introduction

Mentally ill individuals continue to be housed in metropolitan jails to await trial or to serve short sentences.[1] Such patients frequently present serious in-jail management problems because of suicidal, assaultive and disruptive behavior.[2] A recent study estimated psychiatric morbidity in a metropolitan jail to be 4.6%.[3] The majority of those patients suffered from psychotic psychiatric syndromes. Facilities for in-jail psychiatric treatment are seldom available.[4] Out-of-jail facilities are resistant to providing services to prisoners.[5]

The literature on treatment of mentally disordered offenders describes prison,[6–11] hospital[12] and outpatient programs[13, 14] which offer forensic, long-term care or rehabilitative therapy. No descriptions of programs designed to provide acute psychiatric care to jailed patients, except in the context of forensic programs,[15] could be identified.

Community-oriented short-term hospitalization and crisis services are gaining wide acceptance in general psychiatric practice.[16, 17] These techniques are considered to provide effective[18, 19] and economical[20] treatment for most acute psychiatric disorders. They can be adapted to serve highly mobile and severely disturbed patients.[21] Such approaches could be utilized to meet the psychiatric acute care needs of a metropolitan jail population.

This paper describes the development and operation of a jail-based acute care psychiatric clinic which provides short-term and crisis-oriented psychiatric treatment and referral services for inmates suffering from psychotic illnesses and severe situational reactions.

Method

The combined Seattle City and King County Jail facilities provide detention for individuals arrested on felony and misdemeanor charges in King County, Washington, which has a population of 1,100,000 persons. An estimated 20,000 individuals were booked into both jails for the year of 1974. The combined capacity of both facilities is 982 inmates, with an average daily census of 380 male and 40 female inmates. The Seattle/King County Department of Public Health provides medical, psychiatric and dental services to both jails on a contract basis. The clinic had its inception in July, 1972, and continues to the present. Patients included in this study were treated over the one-year period from September 1, 1973 through August 31, 1974.

Interaction with the Community

Mentally disordered inmates had been routinely referred to the local public hospital for psychiatric diagnosis and treatment. An eventual confrontation between the municipal court and the hospital administration over unresolved financial issues and the disruption

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of treatment programs by violent patients resulted in the courts, public health department and hospital administration funding a six-month pilot project through the local mental health board to provide in-jail psychiatric screening and treatment.

Interaction with Jail Administration

The psychiatrist and his staff were to operate under the administrative authority of the local health department, and their services would be integrated with existing medical programs. Control of referrals and psychiatric treatment of inmates would remain with the medical staff. All psychiatric treatment records were to remain part of the medical records and were strictly confidential.

It was agreed that the psychiatric staff would limit their intervention to psychiatric problems, would not interfere with the jail discipline and security, and would exert strict control over psychotropic medications. The psychiatrist requested to serve as a consultant with the jail classification staff in order to facilitate the detection of mentally disordered inmates and to elicit support for the in-jail psychiatric treatment of inmates.

Interaction with Medical Staff

The jail medical staff were unfamiliar with psychiatric medications and techniques. A series of in-service training sessions addressed the issues of psychiatric diagnosis and drug therapy for medical staff. Full responsibility for treatment of psychiatric patients, including psychotropic medication, rested with the psychiatrist.

Procedures

A one-half-time psychiatric resident and half-time faculty psychiatrist from the Department of Psychiatry, University of Washington School of Medicine, staff the clinic. Each psychiatric consultant is on duty in the jail essentially one-half day each day of the week except on weekends. The faculty psychiatrist is available for telephone consultation to support the medical staff for all psychiatric problems on evenings and weekends. Jail medical staff are on duty 24 hours a day, seven days a week.

Admission Procedure

Patients were identified by a variety of methods: The booking officers were required as a matter of form to report on the booking sheet any available medical or psychiatric history. Booking sheets were screened by the medical staff. Classification staff screened all inmates for behavior problems and referred to the psychiatric staff. The medical staff received complaints and observed bizarre and disordered behavior and referred psychiatric patients to the psychiatrist. The inmates themselves submitted written requests for medical and psychiatric care. All referrals were screened by the psychiatrist, with emergent and psychotic patients receiving priority. Legal sanity and competency to stand trial were not addressed and continued to be referred to private psychiatrists. Behavior and discipline problems were referred to the custody staff.

Intervention Procedure

The majority of patients were initially evaluated in the immediate area of their jail cells. This procedure was necessitated by the scarcity of private space in the jail and the inevitable slowdown, inefficiency and psychological trauma to patients inherent in the transportation of disturbed inmates through the jail security system. Physical examina-

tion of psychiatric patients, nonemergent treatments and conventional psychotherapeutic sessions occurred in the infirmary area.

The vast majority of inmates receiving psychiatric treatment remained with the general population. They were closely followed by both the custody and psychiatric staff, and appropriate environmental manipulations were made as needed.

Inmates who required close medication supervision or who presented a serious suicide risk were transferred to the infirmary for treatment. A daily dose-by-dose medication record was kept on each patient. The use of sedative-hypnotic medications was restricted to the short-term management of alcohol and sedative-hypnotic abstinence syndromes. Full range of potent antipsychotic medication, oral and injectible forms, was utilized in the management of psychotic disorders, according to standard practice.

Mentally disordered inmates were allowed to refuse treatment if they presented no manifest danger to self or others. Voluntary psychiatric hospitalization for misdemeanant patients was arranged through negotiations with the municipal court and psychiatric hospitals on an individual basis. Psychiatric hospitalization for felony patients was expedited through contact with the patient's attorney and through recommendations for criminal insanity or competency evaluations at the State facility.

Results

Five hundred and twenty-four patients, 102 females and 422 males, comprised the study sample. Of the total sample, 25 individuals qualified as patients twice, six patients three times and two patients more than three times, for a total of 33 individuals treated more than once. A total of 224 patients were incarcerated on felony charges and 296 patients were incarcerated on misdemeanor charges. Approximately 25 patients were under active treatment on any given date.

Referrals for psychiatric care came from the following sources: medical staff—40%, custody staff—25%, social service staff—21%, out-of-jail resources—8% and fellow inmates—7%. One-third of the patients were evaluated by the psychiatrist within 24 hours of booking.

Referral Problems

Manifestly disordered and violent behavior (fighting, bizarre behavior, suicide attempts) accounted for almost 60% of the referrals (Table I). Only 7% of the referrals resulted from suicide attempts or threats. Simple behavior problems and disciplinary issues were viewed as management issues, not psychiatric problems, and were referred to the custody staff or social services staff.

TABLE I—Referral Problem for 524 Consecutive Psychiatric Patients, King County and Seattle City Jails, Seattle, Washington

Referral Problem	Number	Percentage
Total	524	100
Disruptive/Fighting	137	26
Bizarre Behavior/Incoherent Speech	124	24
Prior Psychiatric Treatment	97	18
Suicide Attempt or Threats	38	7
Anxiety	29	6
Request or Receiving Medication	28	6
Withdrawal/Mutism	27	5
Crying	11	2
Miscellaneous	33	6

Patient Characteristics

The mean age for females was 33.2 years and for males 30.3 years. Eighty percent of all the psychiatric patients claimed contact with a psychiatrist in the past, with misdemeanants having a greater frequency of psychiatric examinations and hospitalizations than the felony group. Suicidal behavior was reported to be a significant past psychiatric problem for many patients, ranging in frequency from 18% for male misdemeanants to 43% for female felons.

Diagnoses

Psychiatric diagnoses were assigned according to the Feighner Criterion.[22] Table II summarizes the diagnoses of these 524 patients. The most frequent diagnoses were schizophrenia, antisocial personality, drug dependence, alcoholism and depression. Schizophrenia was diagnosed in almost 50% of the misdemeanant patients, but in less than 30% of the felon patients.

Treatment

Table III lists the treatments given to the psychiatric patients. Contact with out-of-jail resources occurred in two-thirds of the cases. The treatment of a high proportion of

TABLE II—Psychiatric Diagnosis for 524 Consecutive Psychiatric Patients, King County and Seattle City Jails, Seattle, Washington

	Male		Female	
	Number	Percentage	Number	Percentage
Total	422	100*	102	100*
Schizophrenia	168	40	40	39
Antisocial Personality	130	31	17	17
Drug Dependency	114	27	11	11
Alcoholism	93	22	13	13
Mania	42	10	8	8
Depression	35	8	17	17
Miscellaneous	117	28	28	27

* Total percentage may exceed 100% because of multiple diagnosis for each patient.

TABLE III—Treatment Interventions for 524 Consecutive Psychiatric Patients, King County and Seattle City Jails, Seattle, Washington

Intervention	Number	Percentage*
Total	524	100
Contact with Out of Jail Resources	346	66
Consultation with Custody Staff	302	58
Anti-psychotic Medication	252	48
Environmental Manipulation in the Jail	227	43
Counseling of Three Visits or More	75	14
Anti-anxiety Medication	71	14
Transfer to Psychiatric Hospital	55	11
Place in Jail Infirmary	30	6
Drug Withdrawal Regime	13	2
Anti-depressant Medication	11	2

* Total may exceed 100% because of multiple interventions for each patient.

patients necessitated consultation with custody officers, environmental manipulation within the jail and antipsychotic medication. Only 14% of the patients received conventional psychotherapy consisting of three or more sessions. Medication, regardless of type, was involved in 66% of the cases.

Eleven percent of the patients were assisted in securing voluntary transfer to a psychiatric hospital. All of these patients were accused of misdemeanor charges and release from jail was readily achieved. Hospitalization of patients accused of felonies was more difficult because of the complex court motions and legal procedures required, and recommendations for inpatient treatment were made informally to the patient's attorney. There were no emergency transfers to psychiatric hospitals and no committed persons were included in the total transferred.

Interaction with the Community

Manifest success of the in-jail psychiatric clinic in reducing the incidence of in-jail disruptive behavior by psychiatric patients and referrals to the county hospital for treatment resulted in requests by all concerned for continued funding of the program. As knowledge of the jail psychiatric clinic spread, a large number of community and criminal justice agencies attempted to use the jail psychiatric staff as liaisons between the inmates and their programs. The courts, especially the municipal courts, frequently ordered forensic and pre-sentence evaluations from the clinic for jailed inmates. In such cases, the clinic staff declined the request, reiterated the goals of the program and suggested alternatives to the agency.

Interaction with Custody Staff

The custody staff frequently attempted to have psychiatrists assume full responsibility for the classification decisions on problematic psychiatric patients. The psychiatrists refused and assumed full responsibility only in those cases where the inmate was transferred to the jail infirmary.

Interaction with Medical Staff

The initial pattern for the medical staff to refer large numbers of inmates for psychiatric evaluation with minor problems was reduced both by refusing to evaluate such patients and by encouraging and supporting the staff to provide care to these patients themselves.

Case Illustrations

Case Number 1

A 33 y.o. female, arrested a few hours previously for disturbance and criminal trespass, was referred by the booking officer because of yelling and screaming behavior. The patient had been unapproachable by the custody staff and was found locked alone in a holding cell adjacent to the booking area. She demonstrated rapid speech with pressure, marked anxiety and agitation, and complained of auditory hallucinations. The patient was reassured by the presence of the physician and was able to give a confused history of prolonged hospitalization at the local state hospital, with release six months previously. She was living in a boarding house in the downtown area of this city, and had received no psychiatric followup care since her release.

After some urging by the psychiatrist, the patient agreed to both oral and intramuscular antipsychotic medications. Within two hours, she became much less agitated and

more coherent. After booking, the patient was transferred to a cell for continued antipsychotic treatment. Contact was made with the municipal probation officer, who promptly evaluated the patient, arranged for followup psychiatric care at a local community mental health center, and arranged for the landlady to pick the patient up from jail following her court hearing the following day.

Case Number 2

A 22 y.o. white male was referred to the psychiatric clinic by the on-duty medic who, on rounds, was told by fellow inmates that he had not eaten for two days and that they had taken a razor from the patient after he had threatened to slash his wrists. Multiple superficial lacerations of the right wrist were noted on examination. The patient was mute, silent, sullen and sad in his appearance. His mental status changed over the course of the interview and he became angry and agitated. He gave a history of an extensive juvenile criminal history with multiple institutionalizations, having served an 18-month prison sentence for burglary. His parole revoked, he was expecting to return to prison within the week, where he believed enemies would try to kill him. The patient had no history of prior psychiatric treatment, but did claim one previous suicide attempt from wrist-slashing two years ago when he was initially sentenced to prison. The patient complained of insomnia for the past two days and no appetite.

The patient was given immediate supportive counseling, sedative medication for the night and followup counseling for a total of three sessions. At the end of the week, the patient was transferred to the prison without suicidal incident.

Discussion

The results characterize an operational acute psychiatric treatment program for jail inmates which emphasized crisis intervention and community psychiatric strategies with medical backup. The relative infrequency of emergency transfers to psychiatric hospitals reflected, in part, the effectiveness of this properly supervised and trained professional and paraprofessional medical staff in providing in-jail psychiatric treatment.

The program reported here depended heavily upon a close working relationship between the medical and non-medical jail staff for early case findings and successful implementation of the treatment. The custody staff were important communcation links between the inmates and the medical staff. Without such collaborative endeavors, inmates in need of psychiatric treatment might be overlooked, identified as troublemakers or simply dismissed as manipulative.

Community acceptance of the program followed rapidly. Many community medical and social agencies which had been excluded from the jail sought to use the jail psychiatric clinic to make contact with inmate-clients. The various jurisdictions which had no or poor quality psychiatric services frequently requested evaluations and reports. It became a major problem for the clinic to simultaneously maintain its autonomous medical treatment role and its ability to work with these agencies without alienating them by consistently refusing to respond to their requests.

The choice of a jail-based psychiatric acute care program reflected the lack of out-of-jail psychiatric treatment alternatives for jail inmates. Such an outreach program offered certain advantages. Early case finding was facilitated by the daily presence of psychiatric staff in the jail. Much disordered behavior was recognized and interpreted as psychiatric symptoms. Necessary treatment was instituted rapidly with a minimum delay, with a consequent reduction in patient morbidity. The inevitable disruption in the continuity of care which occurs with the transfer of inmates from institution to institution was largely avoided. Medical and psychiatric problems in all stages of illnesses and recovery were addressed by the same medical staff. Inmates with recurrent problems quickly received needed treatment.

Some disordered inmates were directed out of the criminal justice system and into the mental health care system. Acceptance of referred inmates by out-of-jail psychiatric programs was virtually guaranteed as a consequence of the screening of referrals and the preparation of patients by in-jail psychiatric teams. It is thought that this activity resulted in fewer treatment failures and improved utilization of scarce community resources.

The quality of care offered by such in-jail programs needs to be compared to psychiatric care available in more elaborate medical units. The amount of time per day that a jail patient is involved in active therapeutic program is undoubtedly less than that available in virtually any hospital-based acute treatment program. The physical facilities are primitive and a limited range of treatments is offered. The potential abuse of patients, while not unknown in hospital-based programs, is of constant concern to the jail treatment staff. Great pains were taken to avoid any such occurrences.

The development of appropriate jail and prison services has been hampered by the lack of appropriate professional and financial support and problems over program models.[23, 24] Critics argue that establishment of such outreach programs reduces the pressure on local administrative bodies to develop appropriate, comprehensive out-of-jail treatment programs. The short-range benefits are said to reduce the chances of finding long-range solutions. The question then becomes, how long must one wait for long-range solutions?

Conclusion

Acute psychiatric illness in metropolitan jail inmates can be satisfactorily and economically treated utilizing crisis intervention techniques. The in-jail psychiatric treatment program, linked with a variety of community psychiatric health resources, is one approach to this problem. The jail medical and custody staff were very responsive and supportive with what they perceived as assistance in the management of a very difficult problematic group of individuals.

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