

Psychiatric Hospitalization of Criminal Defendants: New Horizons

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The Richard H. Hutchings Psychiatric Center (HPC), located in Syracuse, is a New York State Mental Hygiene Facility providing mental health services to the Central New York Region. At this time the Center primarily serves the 473,000 residents of Onondaga County; however, when fully operational, it will also provide services to the 287,000 residents of surrounding Madison, Oswego, Cayuga, and Cortland Counties. In consonance with current social policy, HPC functions as a Community Mental Health Center, and, as such, is committed to the treatment and rehabilitation of moderately to severely, and acutely disturbed and chronically handicapped, mentally ill adults and adolescents in its catchment area. Consequently HPC provides many levels of care and treatment in a variety of settings, utilizing and involving all available community resources and the social networks of the catchment area residents.

Most of the catchment area residents requiring direct intervention by HPC are treated by geographical treatment teams. Specialized teams, however, have been developed for individuals who require more directed treatment settings. Examples of this are the Rehabilitation Unit for chronically handicapped individuals, the Skills for Living Program for mentally ill, mentally retarded individuals, the Geriatric Day Care Program for the ambulatory elderly, and the Center for Youth Services for adolescents between the ages of thirteen and eighteen.

Another group of individuals in the Central New York Region who require a specialized treatment setting are individuals who are denied free access to the community by the criminal justice system, have not been adjudicated guilty of any crime, and require inpatient psychiatric care. Specifically these individuals fall into three distinct classes as defined by New York State Law: (1) individuals held in pre-trial detention who require involuntary hospitalization (*per* the Mental Hygiene Law) but must remain in the custody of the Sheriff's Department;¹ (2) felony defendants adjudged to be incompetent to stand trial;² and (3) individuals committed under criminal law following an acquittal by reason of mental disease or defect.³ The HPC Forensic Unit is mandated to provide mental health services to these three classes of individuals.

The Forensic Unit's programs are designed to cope with the complex

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conditions which the literature identifies as negatively influencing the effectiveness of clinical programs with these individuals. There are three principal conditions so identified. The first is an absence in both the mental health and the legal communities of a clear sense of their respective authorities and responsibilities under the law in regard to these individuals, and also of an enduring intention to exercise those responsibilities consistently.⁴ The second is the tendency to treat only the mental illness, disregarding the additional stresses posed by these individuals' most immediate and compelling needs (*i.e.*, those produced by their legal situations and the consequent disruptions of their customary social networks).⁵ Finally, there is a lack of continued support when the individuals return to jail.⁶

As related in the literature, these conditions typically have several undesirable outcomes. The psychiatric commitment is often used as a final disposition of the criminal case, without a trial.⁷ Another predictable result is the 'revolving-door' phenomenon, due to decompensation upon an individual's return to jail.⁸ Finally, when the above conditions prevail, inpatient stays are often very lengthy (even longer than the periods of incarceration that would result from an adjudication of guilt by the courts).⁹ Underlying the Forensic Unit's programs is the hypothesis that a change in these conditions will result in a change in these outcomes.

The HPC Forensic Unit is an experimental facility, providing treatment to these classes of individuals under new conditions. The Forensic Unit's treatment model is designed to affect hospitalized defendants in two ways: directly, through innovative (as regards the hospitalized defendant) clinical programming; and indirectly, through educational and consultative programs designed to affect the legal, clinical, and social contexts in which these individuals find themselves.

The educational and consultative components were developed as the Unit was being formed, and continue as integral parts of the model. These components laid the foundation for the acceptance of the Unit's clinical programs and are seen as ensuring its continued viability. They are conducted both formally (*via* an open house, presentations, written materials, student placements, etc.) and informally (*via* everyday working contacts). The target groups are the legal, mental health, and surrounding lay communities. The goals of these components are: (1) to provide the mental health and legal communities with an understanding of the letter and spirit of the laws governing the psychiatric admission, treatment, and discharge of this population, and with a clear sense of their respective authorities and responsibilities under the law; (2) to provide all the communities with a clear understanding of the goals, philosophy, and programs of the clinical component of the Unit, and to familiarize them with the nature of the patient population; and (3) to assist mental health and criminal justice professionals to develop and implement new administrative and clinical models. To encourage progress towards these goals, a law school graduate and research scientist are full-time staff members. In addition, a resource center containing relevant written and audio-visual materials has been created and is made available to all interested individuals and groups. And, finally, key clinical and administrative staff have been recruited because of their

particular experiences and skills in education and consultation.

The clinical activities of the Forensic Unit are grounded in four principles. The first is that all clinical activities are to be guided by both the letter and spirit of the laws governing the commitment, treatment, and discharge of this patient population. This principle has been adopted to ensure that the purposes of these statutes are faithfully executed by both ourselves and the legal community. The second principle is that effective treatment within the mandate of these commitment statutes necessitates programs which attend to the stresses posed by the patients' most immediate and compelling reality needs in addition to the routine therapeutic measures directed at their underlying psychiatric illnesses. These reality needs arise from fears about and feelings of isolation, abandonment, and loss of control over present and future conditions of life. This means that treatment cannot occur in isolation but must include the patients' attorneys, social support systems, and other community agencies; that is, treatment must respond to the patients' clinical, legal, and social situations. The third principle is that treatment must occur in an atmosphere that recognizes and guarantees the patients' dignity, humanity, and legal rights. Specifically this means that the treatment environment should not be uniquely coercive or punitive and that the patients should be approached with a presumption of legal innocence and without a presumption of dangerousness (at least without one that is greater than that presumed with civilly involuntarily committed patients). The fourth principle is that follow-up services should be provided to patients discharged from the inpatient service. This principle has been adopted in response to reports of decompensation upon patients' returns to the atmospheres where the presenting problems were originally noted. The clinical programs of the Forensic Unit are the products of the implementation of these principles. The following is a brief description of them.

Upon admission an evaluation of each patient's clinical, legal, and social situations is made. The Unit's psychiatrist and psychologist and the patient's case manager assess the individual's clinical situation and then implement the appropriate therapeutic interventions. The Unit's law clerk evaluates the patient's legal situation and determines the type of intervention needed to help the patient cope with that situation. In all cases the law clerk contacts the patient's attorney and informs him/her of his/her client's admission to the Unit, and of the visitation procedure. The law clerk also encourages the attorney to continue working with his/her client. As most attorneys are unfamiliar with this area of the law and are uncomfortable working with the mentally ill, the law clerk often discusses with the attorneys the legal meaning of their clients' admissions, and the purpose and operation of the Unit. The law clerk also offers to meet with the attorneys alone and in conjunction with their clients to aid them in feeling comfortable with their clients and the environment. In addition, the law clerk works with the patients individually and in groups to help them maintain their relationships with their attorneys and to help them understand the proceedings and the roles of the participants in the criminal justice system. The patient's case manager and the psychiatric social worker assess and attend to disruptions in the patient's familial, economic, and social relationships. These activities

range from merely alerting the families to the change in location of their relative and the new visiting hours, to providing conjoint therapy; from notifying the social agencies about the new location of their client, to arranging for financial or other aid.

In addition, a physical and social *milieu* which supports the treatments mentioned above and which itself has therapeutic impact is continually sought. The Forensic Unit is designed to foster an environment that is not physically and socially isolated from the community; that encourages the learning of effective, adaptive behaviors; that enhances the ego strength and identity of the patients; and that responds to their dignity and humanity.

The Forensic Unit occupies half of a three-story brick residential building on the main HPC campus. It is located near downtown Syracuse, is within five minutes' walking distance of the County jail and courts, is bounded by residential, educational, medical, and business complexes, and is readily accessible by all means of transportation. To accommodate this patient population in accordance with the security requirements of the Sheriff's Department (Correction Law §508.3 custody clause¹⁰), some structural modifications were made to the building. Unbreakable lexan windows were installed, locks were placed on all doors, a pine fence was built around the outdoor area designated for the Forensic Unit's use, and easily accessible, breakable, and potentially dangerous items (*e.g.*, mirrors, lights, shelves) were secured or replaced by non-breakable plastic. All modifications were made in such a way as to maintain the physical integrity of the HPC campus, and except for these relatively inconspicuous modifications the physical environment of the Unit is similar to that of the other treatment buildings. In short, the physical structure of the Forensic Unit is designed to have maximum therapeutic impact consonant with current psychiatric treatment theories without jeopardizing its responsibility to return its patients to the courts for determination of the conditions of their release to the community at large. Further, the physical environment is designed to discourage the presumption within the staff, the surrounding community, and the patients that the Unit is for dangerous individuals. And, finally, the location of the Forensic Unit has been chosen to discourage isolation and encourage the continued involvement of the patients' attorneys and social support systems.

The social environment sought is one that allays feelings of isolation, abandonment, and loss of control over the present and future conditions of life. More concretely, a continual effort is made to create an environment that is neither punitive nor coercive, but rather, one that encourages the patients to be actively involved in the Unit's programs and their legal and social situations; supports self-sufficiency, independence, responsibility, and self-respect; and is oriented towards practical reality. In short, the Forensic Unit's social environment is designed to provide a supportive atmosphere in which the patients can learn and test effective ways of handling their present situation.

In support of this objective a large portion of the staff's training program is devoted to inculcating these ideals, and a token economy is employed. The training program emphasizes that our patients are troubled individuals in trouble. It stresses the numerous practical problems these individuals could face and the methods of helping them to do so; and it fosters an

understanding of the environment to which these individuals will be returning, and a general understanding of mental illness and of supportive skills. A token economy system is employed as it allows the patients freedom to choose their levels of participation in activities rather than coercing or cajoling them into participation. The token economy also utilizes positive reinforcement to increase effective functioning and thus includes an intrinsic bias favoring the development of self-sufficiency, self-respect, and effective handling of present reality.

In order to decrease the likelihood of decompensation and recidivism upon the patients' return to jail, an outpatient program situated in the jail to which the patients return was instituted from the beginning. The psychiatric social worker has primary responsibility for this program. The social worker provides supportive services to the patients in jail, and identifies and, if possible, alleviates the stresses affecting them within that environment. Consultation with and training of jail personnel is an important aspect of this individual's work as well.

The realization of the desired social environment and the administration of the Unit are made more challenging by the requirement that deputy sheriffs be present on the Unit. The Center's experience with this situation prior to the opening of the Forensic Unit clearly indicated that the presence of untrained, more or less randomly chosen deputies on a unit run by mental health staff is exceptionally problematic. With rare exceptions the interactions between the staffs of the two different agencies were fraught with distrust and other stresses. Clinical staff typically perceived the presence of deputies not only as counter-therapeutic but also as a fundamental violation of their ideological principles of treatment. Deputies, on the other hand, found themselves surrounded by frightening mental patients and by clinical staff whom they could not trust (and sometimes could not even identify), in a situation devoid of the usual and, from their point of view, necessary architecture for proper custody. In short, it was clear that the presence of deputies on the Unit required close attention and planning. It was decided to work under the hypothesis that if each group understood and respected the responsibilities and skills of the other, it would then be possible for them to work together effectively in areas where their skills and objectives were complementary, to avoid interference with each other where they differed, and to resolve situations where they conflicted. The first step taken to achieve this end was the development of an administrative liaison with the Sheriff's Department. Out of this liaison developed relatively clear-cut guidelines as to the respective authorities and responsibilities of the deputies and clinical staff, and specific procedures for resolving disagreements between them. It was also agreed that the Sheriff's Department would assign a stable cadre of deputies to work on the Unit. In addition, the Forensic Unit was able to select those deputies from a pool of volunteers approved by the Sheriff's Department for this assignment. Finally, it was agreed that the deputies chosen would participate in the five-week training program to be provided to the Forensic Unit staff. It was hoped that within this training period both groups would get to know and begin to trust each other, the deputies would acquire basic mental health skills, and both groups would come to know about and respect each other's

responsibilities and skills.

Extensive data has been collected on the Unit's operation and the patients admitted and discharged from the Unit's opening in December, 1974, to the middle of January, 1976. (A total of 50 individuals were admitted and discharged during this period of time, of whom 43 were admitted on 508.3 status and 7 on 730 status.) The findings regarding the impact of the program will be briefly summarized here. Measured by Rudolf Moos' Ward Atmosphere Scale, the atmosphere of the Forensic Unit, as perceived by the staff, closely approximates that which was desired. In fact, even with the presence of the deputies and the physical restrictions on free movement, the atmosphere of the Forensic Unit is, based on preliminary analyses, little different from that of the mean atmosphere of all the HPC inpatient civil units as perceived by their staff. It was also found that during the year of 1975 there were no significant differences between the proportion of incidents of aggression towards self and others (*i.e.*, attempted suicide, assaults, and fights) occurring on the Forensic Unit and the proportion of those incidents occurring on the HPC civil units. The mean length of stay of these patients was 30 days (the median length of stay was 24 days). Within that time there was an average of two attorney visits per patient who required the assistance of an attorney (9 of the patients did not require an attorney). Also there was an average of 11 family and "significant other" visits per patient. Fifteen individuals were discharged to the jail and 14 of them received follow-up care. Of these 15 only one individual returned to the Forensic Unit prior to the disposition of his charges. The mean days from booking to disposition of the charges was 122 days for the felony charges, 56 days for the misdemeanor charges, and 12 days for the violation charges. Fifty-seven percent of the patients' cases (40% for the patients charged with felonies and 75% for the patients charged with misdemeanors and violations) were disposed of by the courts prior to their discharge from the Unit. This indicates that the Forensic Unit is not being used as a final disposition and that the legal process is continued even though the defendant is hospitalized. Our assumption is that this is primarily a result of our law clerk's activities, of the proximity of the Unit to the judicial facilities, and of the orientation of the Unit toward legal activism.

In summary, the Hutchings Psychiatric Center Forensic Unit is defined as a civil psychiatric treatment service which provides inpatient treatment and follow-up to patients committed to it from its geographic area under three provisions of the New York State Law: §730 and 330 of the Criminal Procedure Law and §508.3 of the Correction Law. The clinical programming is designed to achieve the legally defined purposes of those commitments and to do so with as little delay in the resolution of the client's legal problems as possible. To this end specific programs are employed to deal with the particular stresses and disabilities of the Unit's clients occasioned by their involvement in the criminal justice system. Since the ability to achieve rapid return to trial is a matter which historically appears to be influenced by factors which are strictly neither legal nor clinical, the Unit has programs for educating and influencing the broader contexts of both the mental health and legal systems in which it operates. Since many of the patients return to the setting in which their original

symptoms were first noted, follow-up programs are employed to support the patients upon their return to jail and to decrease the identified stresses within that environment when possible. Finally, the Forensic Unit is seen as extending the services of the community mental health center to individuals not traditionally viewed as eligible for them.

References

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- 2 N. Y. Criminal Procedure Law § 730 (McKinney 1971)
- 3 N. Y. Criminal Procedure Law § 330.20 (McKinney 1971)
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- 9 Acher, Guzman and Lewin, *op. cit.*, n. 4; Hess, Pearsall, Slichter and Thomas, *op. cit.*, n. 4, pp. 383-384; McGarry AL: The fate of psychotic offenders returned for trial. *American Journal of Psychiatry*, 127:1181-1184 (1971); Special Committee on the Study of Commitment Procedures and Law Relation to Incompetents of the Association of the Bar of the City of New York: Mental Illness, Due Process and the Criminal Defendant. New York, ABA, 73, 1968, p. 17, tabl^e 8
- 10 "While the prisoner is in the hospital he shall remain in the custody under sufficient guard of the jail or warden in charge of the jail from which he came." N. Y. Correction Law § 508(3) (McKinney 1974)