

Psychiatric Treatment for Offenders

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Introduction

Forensic psychiatry, correctional psychiatry and psychiatric criminology are the major medical disciplines which address the problems of criminal behavior. Interest in these disciplines has fluctuated from decade to decade and reflects advances in medical knowledge and the realities of practice patterns and changes in professional attitudes.¹ At present, forensic psychiatry has achieved a certain refinement and discipline and claims subspecialty status. Correctional psychiatry, a direct derivative of the healing medical function of medicine and once a prestigious branch of American psychiatry, is not popular. The field is confused about goals and associated with low professional status and poor working conditions. The large numbers of seriously mentally ill inmates in correctional facilities,² civil litigation over inadequate correctional medical care,³ and an increasing medical orientation for psychiatry as a whole, are factors which may move correctional psychiatry back into the mainstream of medicine.

Correctional psychiatry consists of at least two related activities which can be distinguished on the basis of their goals: criminal rehabilitation and psychiatric treatment. Criminal rehabilitation has as its goals the reduction of criminal behavior and is an instrument of the corrections process. The field is dominated by the techniques and principles of mental hygiene and is not a uniquely medical enterprise. Psychiatric treatment, in contrast, has as its goals the diagnosis and treatment of psychiatric illness and is dominated by the treatment philosophy of medicine. Patients with acute and chronic psychiatric illness receive care following standard medical practice.

The medical profession is uniquely responsible for the medical care of the psychiatrically ill offender. The lack of adequate psychiatric treatment for the seriously mentally ill inmate is amply documented.⁴ Guidelines and practical information on the design and operation of psychiatric treatment programs in jails and prisons are not readily available or are incomplete.⁵ This paper will outline the elements of a comprehensive psychiatric treatment program for inmates in jails and prisons.

Method

In 1975, following a survey of health care in the nation's jails,⁶ the American Medical Association obtained an LEAA Grant to develop standards, pilot applications, and an accreditation program based upon the

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standards for comprehensive health care in corrections institutions. In the third year of the project, a Task Force was appointed by the American Medical Association to develop standards for psychiatric services. The Task Force* began work in May 1978, completed the Standards in February 1979, and submitted them to the National Advisory Committee for the Jail and Prison Health Project of the American Medical Association for review.⁷ The Standards outline the essentials of a psychiatric treatment program for correctional institutions and are summarized below.

Results

Organization and Administration

Psychiatric treatment services are considered a part of the correctional facility's medical program. Psychiatric treatment services are separate and distinct from other psychiatric services oriented toward offender rehabilitation and forensic evaluations.

A signed contract between the facility administration and a designated medical authority — a physician, physicians' group, hospital or clinic — is an essential step in defining the operations of the psychiatric treatment services relative to the operation of the institution.

A multi-disciplinary medical team is encouraged as the most effective and economical staffing model. Only appropriately licensed or certified staff will be utilized. The goal is to ensure that the qualifications of psychiatric treatment staff are similar to the qualifications of such personnel in the community. Social workers, counselors and psychologists as well as nurses can function as members of the psychiatric team.

The psychiatric service is only a part of the facility's overall human services program. Alcohol rehabilitation, drop-in centers, classification committees, and corrections counseling are some examples of non-medical human services. The psychiatric staff must cooperate closely with all facility staff. Clinical consultation to non-psychiatric services staff and inservice training for medical and non-medical staff are specifically encouraged (see below).

Jails and prisons are public trusts, often removed from public awareness. Medical advisory committees fill an important need to bring the best talents in the community to help in the problem-solving. The physician responsible for psychiatric services is to work with local medical groups to establish a facility medical advisory committee. The committee is to monitor the operations of the psychiatric service and to support the psychiatric services staff in providing quality medical care. The responsible physician meets with a facilities medical advisory committee on a regular basis. Questions regarding the composition of the committee and the frequency of meetings should reflect the size and character of the facility and prevailing practice.

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Psychiatric services are to be included in appropriate quality assurance programs. Quality assurance programs are one method of assuring quality of medical care and may open the door for funding from state and federal agencies for institutional care. The Medical Advisory Committee may choose to implement their own quality assurance program as part of their monitoring activities.

At least quarterly administrative meetings between the medical authority and the facility administration are to be held to discuss the operation of the psychiatric treatment service. The psychiatric service is to provide a written monthly report and annual summary to the facility administration to assist in program planning and budgeting. Basic information regarding the numbers and character of psychiatric patients, services rendered and problems encountered will help the administration and governing bodies to defend appropriations and improve care.

The physician and the psychiatric treatment team have autonomy regarding psychiatric treatment. Appropriate security regulations applicable to facility staff also apply to psychiatric treatment services personnel.

Services and Procedure

Program priorities for psychiatric treatment services are in decreasing order: 1) recognition and treatment of the severely mentally ill — the psychotic, demented, psychotically depressed or suicidal inmate; 2) recognition and treatment of less severely ill — the anxious and non-psychotically depressed inmates; and 3) psychiatric consultation for the broader institutional human services programs.

The psychiatric patient is defined as any inmate who shows psychological or physiological disturbance resulting in a substantial disorder of thought or mood and significantly impaired judgment, behavior or capacity to recognize reality or ability to cope with ordinary demands of life. The definition includes, but is not limited to, those patients suffering from schizophrenia, manic depressive psychosis, organic mental disorders and stress reactions. Excluded are uncomplicated cases of substance abuse, sexual deviance, antisocial personality, characterologic disorders and mental retardation.

Inmates with problems such as uncomplicated drug abuse, alcoholism and mental retardation identified by psychiatric treatment staff are referred to available human services resources according to written plan.

Psychiatric services staff must coordinate referral and care of patients with other facility staff who provide human services. The goal is to ensure optimal and appropriate utilization of all services. It is the responsibility of the psychiatric services staff to collaborate with and support the development of appropriate programs for all inmates with emphasis on sexual, alcohol and drug problems, the mentally retarded and crisis intervention.

Written standard operating procedure should exist for such clinical operations as receiving screening, diagnostic assessment, emergency care, convalescent care, environmental health, psychiatric hospitalization, post-release planning, notification of family, legal advocacy and routine screening of inmates in isolation or administrative segregation. The goal is to have in place an organized system of service for common psychiatric problems.

All inmates will receive routine screening following booking or admission and before being placed in the general population housing area. The method of receiving screening should include review of records which accompany the inmate, routine questions regarding health history and observations of mental status and behavior. The initial screening assessment may be performed by a trained jailor or custody officer. Findings are recorded and reviewed. The receiving screening should differentiate between those who need immediate care and those requiring more routine care. Inmates with psychiatric illnesses are referred for further assessment. Any subsequent psychiatric workup is the responsibility of the psychiatric treatment staff. Patients with emergent problems are placed under close observation and care is rendered within hours. Complete psychiatric evaluations of emergency and routine cases are to be completed within fourteen days of admission to the facility. In thirty days, a written psychiatric treatment plan will be in the chart. Many, if not most, referrals will come at the time of the admission screening. Some will come later as facility staff spend more time with inmates. A procedure to provide 24-hour access of inmates to help for emergency problems and to provide daily referral of non-emergent problems to psychiatric treatment services is necessary. Corrections officers and other human services staff are to be trained in recognition of symptoms of severe psychiatric illness and can provide 24-hour-a-day observation. The obligation of the custody staff is to refer disturbed inmates to the psychiatric treatment personnel for screening and treatment. Any facility staff may refer inmates to the psychiatric treatment services at any time when they are suspected of suffering psychiatric illness. A written procedure should be provided for such referrals.

Chronic as well as acute care is to be provided to inmates within the facility. Larger facilities can develop inhouse infirmaries or hospital units to take care of some patients. Small facilities may not have the necessary resources and must rely on other facilities. In no case is a correctional facility to function as an inadequate substitute for proper medical care. Whenever the management needs of the patient exceed the ability of the medical staff to respond, the patient will be transferred to an appropriate facility where appropriate care can be provided. Prompt and ready transfer of inmates is facilitated by written policies and procedures, pre-negotiated written transfer agreements and advocacy by the facility administration and the medical advisory committee.

All psychiatric data is recorded in the unit medical records. Access to the medical record is controlled by the responsible physician. The principle of confidentiality applies except when excluded by law or necessary to protect the welfare of the individual or the community. The medical record is maintained separate from the confinement record. Written authorization is necessary to transfer medical record information. Permission should be routinely sought to send relevant medical information to any facility to which the inmate is transferred.

Adequate space, equipment and supplies, and materials as determined by the medical authority are provided for the delivery of such services. The extent of these facilities will reflect the level of medical care provided and the degree of utilization of outside resources. Reasonably private space for

examinations, a secure place for medical records, a telephone and good general security are the minimum requirements for the treatment of outpatients. When inpatient care is provided, a suitable secure inpatient facility with adequate staff separate from segregation areas is needed.

Psychiatric resources are used only for psychiatric treatment. In some institutions, psychiatric treatment staff are frequently called upon to provide control of non-psychiatrically ill inmates. Such activities are abuses of psychiatric resources and an inappropriate use of medical care. Psychiatric staff can appropriately screen disruptive inmates for psychiatric illness and consult with their human services colleagues regarding humane management strategies.

Written operating procedures for the proper management of pharmaceuticals include a formulary and policies regarding the prescription of psychiatric medications and all medications subject to abuse. Medication is administered only by trained personnel in accordance with state laws. Stop orders at thirty days and mandatory review before renewal of medications are considered good medical practice.

A disaster plan must be an element of the psychiatric treatment program. Mass casualties can be expected from riots, fires and other natural disasters. A plan for coping with such extraordinary circumstances is an important element of the overall medical services program. Specific psychiatric services should be provided for disaster victims, staff and inmates alike and a communications network set up for family and friends.

Training

A written plan for orientation training and regular continuing education of psychiatric treatment staff is essential. Psychiatric care in jails and prisons is a unique task which often requires orientation for new personnel. All levels of psychiatric staff require regular and continuing education in order to provide the highest quality of care. The plan should be consistent with the training requirements mandated by the relevant state licensing boards.

All facility personnel, custody and non-medical human services staff should receive training regarding the recognition and treatment of psychiatric illness, in a program approved by the responsible physician. The detection of psychiatrically ill persons requires that all staff be trained in the recognition of psychiatric symptoms and in the use of appropriate referral resources. Medical services personnel should play a major role in the training of staff.

Legal Issues

All aspects of the psychiatric services conform to applicable state and federal law and regulations. The quality of psychiatric care can be compromised if applicable laws are ignored or not applied.

Adherence to applicable state and federal licensing and certification laws is basic and described above.

All psychiatric examinations, treatments, and procedures affected by the principle of informed consent are followed for inmate care. In the case of minors, informed consent of the patient's parent, guardian or legal custodian applies where required by law. Informed consent is the permission granted

by the patient for the performance of examination or treatment procedure, after the patient receives material facts regarding the nature and consequences, risks and alternatives. Informed consent may not be necessary in all cases. Examples of such situations are unexpected emergencies which require immediate medical intervention, a patient who does not have the capacity to understand the information because of incidence of severe psychiatric illness, or public health matters. In such instances, it is advisable that all aspects of the patient's condition be documented in the medical record, including reasons for medical intervention. In certain exceptional cases, a court order may be sought in order to render treatment.

Written procedures to outline the provision of involuntary psychiatric treatment in accordance with state and federal laws applicable to the jurisdiction must be developed. In the past, it was common practice to transfer corrections inmates to mental hospital facilities. Involuntary commitment procedure laws in many states now prohibit this. The problem remains — how does one provide acute psychiatric care to unwilling patients? Policies and procedure and pre-negotiated transfer agreements will facilitate such care by providing the necessary mechanisms and structure and by protecting staff from real or imagined legal reprisals.

Policies for the use of physical restraint include, but are not limited to, locked rooms, special cells, handcuffs, and leather restraints. Restraints are part of the medical regime when used as part of the psychiatric treatment program. Psychiatric staff is not responsible for the administrative restraint of destructive inmates. Routine medical screening of such administratively confined inmates is a standard medical practice, because of the high risk of medical complications.

When psychiatric illness is identified in a pre-trial detainee, the court and/or inmate's attorney are notified according to written procedure. Every effort should be made to notify the inmate's advocate of the psychiatric illness. Afflicted individuals are often incapable of communicating effectively with their advocates. The facilities psychiatric treatment team is not expected to provide forensic testimony but rather to render psychiatric care in the facility. The court has the obligation to provide psychiatric experts for forensic purposes.

Research on the epidemiology of psychiatric illness and improved methods of health care delivery for corrections inmates is expressly encouraged. Such research efforts are essential if the quality of medical care is to be evaluated and improved. Research with no immediate application to the inmates' medical condition, *i.e.*, drug trials, etc., is discouraged.

Discussion

The Standards sketch in broad strokes the comprehensive structure and function of psychiatric treatment programs for correctional institutions. The Standards do not include data regarding specific manpower and other resource requirements. These aspects of a care program must be tailored to the unique needs of each facility by those responsible for its operation.

Standards such as those developed by the American Medical Association can provide a concrete basis from which an interested group or groups can develop an accreditation process for correctional psychiatric treatment

programs. An accreditation process would provide advocates within and outside the correctional institutions a powerful means to upgrade the quality of psychiatric services. A group similar to the Joint Commission on Accreditation of Hospitals could mandate program compliance before licensing or certain types of funding could be given.

Independent of any accreditation process, program administrators and corrections officials interested in quality care will find the Standards useful in program planning and for budgeting. Clinicians can turn to the Standards to help them define the scope of the medical problems for program planning, for training and for priority-setting. The result is to help clinicians cope with the classic correctional dilemma of whether to spread limited resources so thin as to provide a little (inadequate) care to everyone or to provide quality care to just a few (and ignore the others). With proper planning and goals established, resources are obtained and alternatives identified.

The correctional facility is only one of the community's resources for dealing with disruptive citizens. The community is also responsible for meeting the health needs of inmates of correctional facilities. Correctional staff have too long functioned in isolation with respect to the community. The result is a climate of suspicion and distrust between the facility and the community at large and poor health services to inmates. Getting rid of the psychiatrically ill inmate by routine transfer to a state hospital is not always possible, nor always consistent with modern approaches to psychiatric treatment. Increased effort must be expended to provide services using local resources. This philosophy is inherent in the Standards developed by the American Medical Association.

The Standards are applicable and practical for large and small facilities, jails and prisons alike. The need for acute services is felt most keenly in jail facilities. Most of the nation's jails are less than 24 beds in size. The Standards may appear overwhelming at first, especially for small facilities where written protocols and formal organization are less likely to be the operating format. Gradual change is the first requirement for the successful implementation of the Standards. A model program embodying essentially all the principles of the Standards is operational in an eight-bed rural jail and staffed by a part-time social worker.⁸ More elaborate programs are necessary and feasible in larger prisons.

The major complaint regarding these Standards has been the impossibility of implementing an entire program in most small jails. That is exactly the point of the Standards — that care cannot be compromised because of facility size and staffing problems. Every successful program has found it necessary to collaborate with an out-of-jail resource such as a mental health center, group practice or hospital to provide a program. The care of the mentally ill inmate is a community responsibility.

Only by defining the proper lines of authority and areas of responsibility can quality psychiatric services be delivered. Psychiatric services are characterized as a separate and important medical element of the overall mental health or human services program for the correctional facility. Psychiatric patients are defined as those inmates with dementia, psychosis, depression, suicidal behavior, psychophysiological conditions and severe anxiety. Those problems require medical management in a medical system.

Counseling, crisis intervention, drug and alcohol rehabilitation, support for the retarded inmate and behavior modification for the non-psychiatrically ill are not uniquely medical activities and belong to the broader field of human services. Non-medical professionals, *i.e.*, social workers or psychologists, may provide psychiatric services under the direction of a medical professional.

Inmates with uncomplicated behavioral problems do not necessarily become psychiatric patients nor the responsibility of the medical staff. Instead, they are referred to either their correctional or other mental health staff for management.

Conflict is inevitable with any definition of psychiatric illness. Diagnoses fall short of describing the range of mental health needs of the patients. Non-patients frequently are labelled with psychiatric diagnoses. Rehabilitation of inmates with psychiatric diagnoses, *e.g.*, antisocial personality, may be best effected by non-psychiatric care. The intent of the definition of the Standards is to direct those inmates most in need of psychiatric treatment to medical staff. Rehabilitation of socially deviant individuals is a separate but related human services function. The Standards promote the development and viability of non-psychiatric human services primarily by not imposing on them the "medical model." Room is left for non-medical professionals to bring their best expertise to bear upon human problems unencumbered by the philosophy and practices of a related but different discipline. A physician may consult with any human or rehabilitation service under the direction of a qualified human services professional.

Close cooperation between the psychiatric and other human services is supported by attention given to staff training, procedures for cross referrals and guidelines for administrative interaction. Patient advocacy is another approach specified in the Standards to promote both good psychiatric care and adequate human services. A burden is placed upon the medical staff to respond to their patients' non-medical human needs and refer them to the proper resources.

The emphasis on written policy and protocol is essential to promote accountability, communications between staff, continuity of care and continuation of programs with changing staff. Experienced correctional medical staff agree that major impediments to the efficient and effective delivery of care are confusion and uncertainty regarding policy and procedures and poor communication.

Correctional psychiatry should strive to provide basic psychiatric care to inmates of the jails and prisons. The delivery of such care should receive the priority of correctional psychiatrists and funding agencies. It is that branch of correctional psychiatry that has at the present time the most to offer the offenders.

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