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A Consultant's Survey of the Patients in a Maximum Security Hospital

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ABSTRACT: The patients at a state maximum security forensic facility were interviewed by a psychiatrist and their files reviewed. Only 43 of the 203 patients were judged to be suitable for the facility. Nearly 60% of the pretrial defendants were judged to be capable of proceeding to trial. Of the patients, 18% were judged to be malingering or avoiding trial or prison. The implications of these findings are discussed.

KEYWORDS: psychiatry, jurisprudence, mental illness, surveys

Patients in a forensic state hospital are subject to two simultaneous sets of legal input: those reflecting the Mental Health Act regarding voluntary and involuntary hospitalizations, and those concerned with the defendant or offender's status within the criminal justice and correctional systems. Since the use of forensic hospitals should be limited to treating persons who are either criminal defendants or offenders, the confinement of civilly committed patients who are without current criminal justice system involvement would appear, on face value, to be inappropriate. Moreover, when forensic hospital facilities are classified according to various degrees of security (maximum, medium, or minimum security), the mental health laws pertaining to the concept of least restrictive alternative are often applied as a *secondary* standard, with higher security consideration being given to the nature of the charge or conviction involved.

Maximum security forensic hospital caseloads, including those mentally ill persons who might be better placed under less restrictive clinical circumstances [*1*], are often managed on the basis of criminal justice considerations rather than of clinical considerations.

Unfortunately, patient referrals to the maximum security facility have sometimes become extravagant and inappropriate. Presentence commitments frequently remain far beyond the given number of days allotted by state law because the facility may lack the capacity for assertiveness with courts and any assurance that the detentioner will be taken back at the end of his commitment time. Some patients housed in maximum security institutions reflect the so-called "criminalization of the mentally ill"—persons charged with minor crimes as,

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for example, uttering terroristic threats. Since these offenders are not dangerous, as such, they do not require the more restrictive facilities of maximum security. Pretrial patients may also be left to remain at the state facility longer than necessary as a defense attorney's adversarial tactic rather than a requirement of hospital treatment.

Civil patients are all too frequently referred from immediate security or less restrictive alternatives to maximum security facilities as repository cases, or as difficult cases who are episodically assaultive and clinical management problems in general. Their return to the original hospital or referral, however, can be refused for years. The presence of such patients diverted to and then abandoned (by courts and other state hospitals) at the maximum security state facility for as long as 20 years or more is not unheard of. Not only is this practice considered "inhumane," but it has also resulted in expensive litigation seeking negligence and civil rights damages from the States, for example, *Dixon v. Attorney General of PA* [2].

Community and political factors reflecting fear also add to the problem of inappropriate and undue retention. No community wants to house patients uniformly viewed not only as dangerous but also insane [3].

Mainly for these reasons, many of our country's maximum security hospitals have become either state or county repositories ("dumping grounds") for difficult cases, or a refuge from the penitentiary by unofficial "volunteer" sentenced prisoners manipulating both the justice and the mental health systems.

The present paper reports on a clinical review of patients at one large state maximum security forensic hospital, conducted by an independent forensic psychiatric consultant having no official connection with that hospital. With a view toward the appropriate use of maximum security forensic facilities, the purpose of the clinical evaluation was to identify patients suitable for transfer or discharge to other, less-restrictive alternative placement and to identify factors which contribute to inappropriate admission or undue retention of patients or both.

The particular maximum security forensic hospital studied serves both the criminal justice and mental health systems, as well as the patients who fall into the cracks between the two systems. Housing only male patients, the institution contains sentenced prisoners, pretrial defendants, and civil patients, in addition to a small number of persons found not guilty by reason of insanity. The State has defended against lawsuits, as well as major class actions involving individual patients allegedly kept inappropriately. Legal vulnerability, therefore, warrants continued attention.

Method

Before the site visit for a clinical evaluation of patients, the face sheet, initial workup summary, and most recent progress reports of each patient were studied and classified according to demographic, clinical, and forensic categories, as well as legal commitment status. This was performed by a Board Certified psychiatric consultant with clinical and forensic experience, as well as long-standing familiarity with the state hospital and the mental health and criminal justice systems.

Following an extensive case analysis, the same psychiatrist then performed an individual chart review in the presence of each of the 203 patients (as of the April 1980 census date in which the study was initiated).

On each ward the psychiatrist was seated at a large table containing all of the patients' charts, together with several institution staff. Patients were brought in individually (in alphabetical order), informed of the purpose of the chart review, and then asked if they were willing to participate. In only two instances did patients refuse permission, and they were returned to the ward. In six additional cases, psychotic patients were too disoriented to communicate.

In all other instances, the examining psychiatrist reviewed the patient's charts in the presence of each patient, asking a series of questions pertaining to the patient's experience at the hospital, potential alternative management elsewhere, his medication, degree of insight into his clinical and legal problems, and general mental functioning and outlook. In addition to informed consent, the patient's view of his treatment, legal status, and treatment prospects were reviewed as candidly as possible as the patient's clinical condition allowed, consistent with Section 107 of the Mental Health Procedures Act (Pennsylvania).

Following the completion of the chart review with each patient, uniform data were assembled and tabulated for the identification and analysis of pertinent demographic, clinical, and forensic findings.

Results

The total population of 203 patients consisted of 76 sentenced prisoners, 61 pretrial defendants, 60 civil patients, and 6 offenders found not guilty by reason of insanity (NGRI). Of the total group, 92 were black and 111 white. Thus blacks were present in a greater proportion than would be expected from their representation in the general population.

The civil patients (mean age 41.2 years) and NGRI offenders (mean age 40.7 years) were older than sentenced prisoners (mean age 33.0 years) and pretrial defendants (mean age 32.5 years). Age differences were mainly because a large number of civil patients and NGRI patients had been in the institution for a long time, and had grown old there. For example, 47% of the civil patients and 50% of the NGRI patients had been in the institution for 5 or more years as compared with only 4% of the sentenced prisoners and 2% of the pretrial defendants. Slightly more than half of all patients (51%) had been in the institution for less than a year, and 8% had been there for 20 years or longer.

The ward distribution of the patients was reflective of their clinical and behavioral symptoms rather than their commitment status or involvement in the criminal justice system. Thus, sentenced prisoners, pretrial defendants, and civil patients shared ward space with one another.

The 76 sentenced prisoners and 61 pretrial defendants had been sentenced for or charged with 55 homicides, 8 forcible rapes, 6 nonviolent sex offenses, 5 cases of arson, 30 simple or aggravated assaults, and 33 property (and other) crimes.

Clinical Findings

When asked whether they were willing to participate in the review of their chart, 195 patients (96%) both understood and were willing to participate. Of those evaluated, 57% of the patients were judged capable of understanding their present legal status, and 61% were judged capable of understanding their clinical status. Nearly 60% of the pretrial defendants could proceed to trial; 43% were judged competent to stand trial without medication and a further 16% competent to stand trial if medicated.

Of the patients, 29 wished to remain at the facility (43% of the sentenced prisoners, 20% of the pretrial defendants, and 22% of the civil patients). Approximately 18% of the patients were judged to be malingering or avoiding trial or prison (including 15% of the pretrial defendants and 38% of the sentenced prisoners).

The diagnostic findings of patients, as shown in Table 1, indicate that psychosis, overt or in remission, was the diagnosis most often made. The dispositional recommendation for each patient can be found in Table 2, where it is apparent that only 20% of the patients were judged, without question, to be appropriately housed in the facility.

TABLE 1—*Diagnostic findings for the patients.*

	Number	Percent of 203
Schizophrenic psychosis, overt	60	30
Schizophrenic psychosis, in remission	77	38
Affective psychosis, overt	5	2
Affective psychosis, in remission	4	2
Organic psychosis, overt	14	7
Organic psychosis, in remission	13	6
Personality disorder without psychosis	27	13
Mental retardation	30	15
Mild	16	8
Moderate	13	6
Severe	1	1
Epileptic with any of the above	16	8
Elderly patients in need of shelter, nursing care	13	7
Disabling neurological disorder, Huntington's Chorea	1	1

TABLE 2—*Recommended dispositions for the patients.*

	Number	Percent of 203
Should clearly remain at maximum security facility	43	21
Wants to leave facility and clearly should	82	40
Pretrial or presentence competent	28	14
Sentenced, competent	25	12
Civil, treatable elsewhere	29	14
Wants to leave facility, but borderline	17	8
Primarily retarded, requires state school	8	4
Should be transferred to civil hospital	41	20
Forensic patient transferrable to medium security facility	20	10
Civil, assaultive patient transferrable to State hospital	8	4
State hospital clinical management problem returnable to State hospital	25	12
State school management problem returnable to State school	8	4
borderline	1	1
Elderly patient (65+) requiring nursing care/shelter	13	6
Wants to stay at facility	8	4
Willing to leave facility	5	2
Needs lawyer for release or transfer	33	16

Discussion

Granted an inevitable degree of variance in professional opinion and interpretation of findings, the foregoing assessments reflect conservative, unhurried, and carefully considered forensic/clinical judgments made following the repeated review of the findings and clinical data in each case. The assessments are internally consistent for rater-reliability since they are based on the findings of the same examiner during a single survey.

Nearly all patients (95%) were capable of understanding the purpose of the interview, and of granting or denying consent. The vast majority of patients were willing and capable of talking about themselves, their circumstances, and their problems. The interviewer judged 79 (39%) of the patients to be overtly psychotic, and an additional 92 patients (45%) previously psychotic but in full or partial remission.

Examination of the pretrial defendants indicated that nearly 60% were competent and could proceed to trial. These figures indicate that the professional staff of the facility tended to lag behind changes in the patient's psychiatric status. Patients now in remission were not immediately recognized as such; patients competent to stand trial were not immediately evaluated as such.

Examination of the 76 sentenced prisoners revealed that 38% were without psychosis, but preferred to remain at the institution rather than be returned to prison. Of these patients, several indicated that they would attempt suicide or assault others to remain at the present facility. Similar remarks were made by 35% of the competent pretrial defendants. Thus, the institution seems to be viewed as a safe haven by many patients who belong in the criminal justice correctional system. The majority of these patients were being treated as if they were suffering from psychiatric illness, with many receiving substantial doses of psychotropic medication.

The institution clearly accepts patients from a variety of sources. However, only 21% were judged as clearly appropriate for retention by the institution. Of the patients, 40% were judged to be quite capable of management elsewhere, including 28 pretrial defendants, 25 sentenced prisoners, and 20 civil patients. Again, the majority of these patients were receiving psychotropic medication.

Eight patients were clearly retarded with no evidence of psychosis. Each would appear to belong in a state school for the retarded. Twenty-five of the civil patients represented chronic management problems from the state psychiatric system. Such patients could be handled by the state psychiatric system which should devise procedures for the management of such patients. Fourteen of the patients at the institution primarily required nursing care and a sheltered environment, and these patients should be transferred to more appropriate institutions.

In addition, 16% of the patients had remained in the institution for periods longer than that required by law as punishment for their crimes. Thus, these patients were in need of a lawyer to petition the courts for release or transfer.

Conclusions

The forensic hospital is a facility of last resort, appropriate for persons involved in the criminal justice system who are so mentally ill that there seems no alternative for a state than to maintain a so-called maximum security forensic facility. The problem is that a facility such as this becomes a convenient dumping ground for the most difficult management problems of both the correctional and county court systems which have no other facilities available for the management of reportedly highly disturbed defendants and offenders.

Since the prospects for remission of mental illness are usually more favorable than those for cure, wardens and judges alike are understandably reluctant to receive offenders and defendants back from a forensic hospital, having had the repeated experience that such patients frequently undergo mild remissions before return to the local jail or state penitentiary. Thus, not only do wardens and courts pursue a conservative approach with respect to hospital stay, but so do the clinicians at maximum state hospitals who have no way of guaranteeing that their discharged and transferred patients will not suffer a relapse, or even receive basic follow-up and reliable maintenance of prescribed antipsychotic medication.

To remedy this situation, we need to establish and maintain less restrictive treatment facilities, available to courts and the county prison system, in which prescribed medication can

be obtained and psychiatric evaluations updated locally without the need to transfer such patients back again to the maximum security state hospital. The result will be a monetary savings for the hospital, alleviation of overcrowding, and freeing space for those who do require both hospitalization facilities and maximum security. It will also improve the general demoralizing effects on a system which must serve two masters: the mental health authorities and the judge and warden involved in each case.

The remedies suggested would then solve two problems:

1. Ensure mentally ill persons charged with a crime a speedy trial, even if psychotic, or treatment if the defendant is incompetent to stand trial.
2. Offer general requirements for superintendents of less restrictive state hospitals to provide seclusion/restraint and alternative treatment measures for persons who are mentally ill, assaultive, or clinical management problems.

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