Legal and Ethical Challenges in Emergency Psychiatry, Part 2

Management of Inmates

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KEYWORDS

• Emergency psychiatry • Inmates • Ethics • Legal

KEY POINTS

- Physicians and clinicians need to provide care and treatment of jail and prison inmates with the same medical professional and ethical standards.
- Inmates have a right to treatment/right to refuse treatment. Although their treatment choices may be limited, they have to undergo the informed consent process.
- Inmates have limited confidentiality: clinicians have to balance an inmate's needs/right to confidentiality with a facility's responsibilities for safety of other inmates and correctional staff.
- Inmates have unique situational and correctional facility challenges that have to be carefully factored into the disposition and treatment planning processes.
- Inmates have a high suicide risk. Clinicians need to ascertain additional inmate-specific risk factors into their suicide risk assessment and intervention.

INTRODUCTION

In 2014, the number of incarcerated individuals in the United States totaled 744,660 for jails and 1,561,550 for prisons.[1] Approximately 16% of inmates in jails and prisons have serious mental illness[2] and suicide is the leading cause of death in jails.[3] More than two-thirds of individuals meet criteria for a substance use disorder at the time of entry to jail.[4] Correctional facilities often use community medical resources, especially for emergency medical and psychiatric services.[5]

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Psychiatrists may be asked to evaluate inmates in an emergency department, which presents unique ethical and legal issues. For psychiatrists who seldom encounter an inmate patient, this may be an unfamiliar situation. A basic outline of correctional facilities and systems is given to assist psychiatrists in these situations. The ethical and legal issues examined include the constitutional right to treatment and to refuse treatment, the physician-patient relationship, confidentiality, and the importance of suicide prevention. Lastly, practical general guidelines provided by the American College of Emergency Physicians may also be helpful for psychiatrists working with inmates in emergency departments.

CORRECTIONAL SYSTEMS

A typical inmate patient scenario presenting to an emergency department is the case of a 55-year-old man who is brought in from the local county jail after being found in his cell hanging from the ventilation grate by bed sheets around his neck.

When treating inmates from a correctional facility, it is important to have an understanding of correctional systems and their settings. In general, individuals held in a correctional facility are referred to as *detainees* before trial and as *offenders* after sentencing.[6] For simplicity, this article uses inmates to refer to both despite clear legal differences. Correctional facilities generally include lockups, jails, and prisons that are maintained by local, state, and federal agencies, respectively. Lockups are temporary holding facilities (usually <48 hours) typically located in police departments. They hold individuals who have been arrested or charged and have completed the initial administrative booking process and are waiting for court arraignment. Additionally, police may bring individuals requiring a mental health evaluation to an emergency department prior to arrest or booking.

Jails are locally operated facilities that generally hold both detainees awaiting trial and offenders convicted of misdemeanors and other minor crimes with a sentence of up to 1 year. Prisons are operated by state or federal governments and typically confine offenders convicted of a felony with a minimum of a 1-year sentence.[6]

Individuals recently arrested and waiting in jail for a court date must adjust to acutely high stress levels with tremendous uncertainty about their legal and personal future.[7] Individuals who have been sentenced have a more certain legal future (unless they acquire additional charges) but must continue to adjust to separation from family and established social support systems and contend with potential relational institutional conflicts.

RIGHT TO TREATMENT AND RIGHT TO REFUSE TREATMENT

Over the past 40 years, many legal cases have brought reform for inmates with mental illness, which have addressed both the right to treatment and the right to refuse treatment. The US Supreme Court in *Estelle v Gamble* (1976) held that officials must provide adequate medical care to convicted prisoners.[8] Failure to provide care violates the prohibition of cruel and unusual punishment in the Eighth Amendment. The Fourth Circuit Court of Appeals in *Bowing v Godwin* (1977) clarified this requirement to include mental health treatment.[9] The right to treatment was extended to pretrial detainees by the US Supreme Court decision *Bell v Wolfish* (1979) based on the Due Process Clause of the Fourteenth Amendment.[10] In *Ruiz v Estelle* (1980), the Southern District of Texas Court set minimum standards for mental health treatment of prisoners.[11] The US Supreme Court annotated procedural protections in *Vitek v Jones* (1980) for prisoners who may be involuntarily transferred to psychiatric hospitals.[12] This included the right to an adversarial hearing and legal assistance and the