

Psychiatry Behind Bars

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The pressing need for psychiatric services within the nation's jails and prisons is well documented. A study sponsored by the American Medical Association in 1973 reported that only 13 percent of the nation's jails had psychiatric services for mentally ill inmates.¹ This lack is even more disturbing when psychiatric morbidity rates of jailed persons is noted. Rates vary, depending on the nature of the facility and the manner in which psychiatric morbidity is defined.² A study of five California facilities in Los Angeles County reported 6.7 percent of all inmates to be psychotic and 9.3 percent of inmates to be suffering from a nonpsychotic disorder.³ A study of the Alabama state prison system showed 10 percent of inmates to be psychotic, while approximately 60 percent of all inmates had "severe psychiatric disturbances."⁴ Further support of the need for psychiatric services within jails and prisons is offered by the observed clinical relationship between crime and mental illness, especially with reference to certain subgroups of the mentally ill who are arrested more frequently than average people.⁵ An even more complex relationship exists between mental health legislation, psychiatric institutionalization, and the so-called "criminalization" of the mentally ill.⁶ Studies suggest that restrictive civil commitment practices have increased the number of mentally ill persons who find their way into the criminal justice system, ultimately requiring psychiatric care.⁷⁻¹⁰

Despite this well-documented need, psychiatric services within jails and prisons remain "the most necessary but the least available health services for inmates."¹¹ Prison psychiatry, as opposed to the broader and currently more popular subspecialty of forensic psychiatry, remains an underpopulated field. Halleck, in an earlier study as well as in a more recent editorial, pointed out the paucity of psychiatrists available for prison work, which is considered by many to be "neither professionally nor financially rewarding."^{12,13}

This article, based on the author's experience as a staff psychiatrist in a county jail, attempts to define the clinical issues, problems, and deterrents faced by a general psychiatrist working in such a setting. My work was in a 204-bed jail with approximately 850 admissions annually, serving a northeastern county of 479,000 inhabitants. Although this is a county jail, many issues encountered are applicable to work within any "correctional" facility, be it local, state, or federal.

Prison Conditions

Our nation's prisons are old, dirty, and overcrowded. The deplorable physical conditions in many jails have been discussed by various distinguished authors.¹⁴

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A popular periodical reports a near doubling of the United States prison population since 1970, with a 12.1 percent increase during 1981 alone.¹⁵ This inmate population increase and the debate over ever-increasing prison construction costs insure that the lack of modern, safe physical surroundings will continue to be a fundamental problem facing our jails and prisons. Prisons present an "emotionally stressful and physically dangerous environment" that not only affects staff employed therein, but also has a profound effect on the mental health of inmates.¹³ Roth and Ervin, in a study of a medium-security federal penitentiary, found that 4 percent of all inmates suffered onset of a psychosis for the first time during imprisonment.¹⁶ Kaufman, in his study of three "prison systems in different areas of the United States," likened the physical conditions in these facilities to "descriptions of the pre-Pinel era at the Bicêtre and Salpêtrière in eighteenth century France."¹⁷

In addition to uninviting and, at times, menacing surroundings, other issues have discouraged general psychiatrists from work within the prison system. One such issue has been the de-emphasis on rehabilitation, especially with regard to the sociopathic offender.¹⁷ This therapeutic nihilism, when applied to all prison inmates, however, is misplaced. Although a significant subpopulation of inmates are described as chronic, repeat offenders (some estimate as high as 30 percent), not all discharged inmates will return to jail.¹⁵ Even when dealing with the characterologically disturbed inmate, the experience of incarceration itself, which has been likened to a powerful "ecological shock," can further "damage the personalities of prisoners," leading to a variety of acute psychiatric disturbances that require immediate, if not emergency, intervention.¹⁸ Jails are stressful, disturbing environments where inmates suffer the frustration of instinctual needs, separation from much-needed objects of support, and the dehumanization that is part of incarceration itself. In county facilities where inmates are admitted "from the street," the number of inmates with acute psychiatric disturbances, including drug and alcohol dependence, acute psychosis, and depression with suicidal ideation, can be striking and at times overwhelming.

Psychiatric services within a jail or prison can act to decrease the degree of stress associated with incarceration and provide a humane influence within the environment. Although there are notable exceptions, such enlightenment is not shared by all prison administrators or correctional staff (not to mention legislators, funding bodies, and psychiatrists themselves). The general psychiatrist working within the prison may at times feel his professional opinions and treatment strategies are politely ignored or actively opposed. These conflicts between treating staff and correctional staff are minimized with good communication and the eventual development of mutual trust and respect, but for the general psychiatrist accustomed to the traditional hospital model of psychiatry or the private office, this initial response to his efforts can cause him to develop considerable ambivalence regarding his role within the prison. Also at odds with the psychiatrist's notion of a therapeutic milieu is the organization of the prison itself with its rigid rules and emphasis on control, conformity, and anonymity.

General psychiatrists new to the prison system may not be familiar with the

forensic issues encountered in such a setting. Psychiatrists are often trained to interact solely with their patients without regard to outside parties such as public defenders, judges, probation officers, and the like. While attempting to balance the needs of the inmates with the rules of the institution and the demands of society, the prison psychiatrist may experience conflicting allegiances. These conflicts can be experienced most keenly during interviews in preparation for court-ordered evaluations. It is during such evaluations (especially with regard to presentence/parole board recommendations) that the needs and rights of the inmate cum patient may be clouded by the psychiatrist's own values — and the values of society at large. While this is a problem not easily addressed, the needs of both inmate and society must be considered and weighed carefully by the psychiatrist, who must also be aware of his own particular values. Inmates are at times reluctant to share important clinical information with treatment staff due to legal implications. The prison psychiatrist must be careful to inform inmates of the limits of confidentiality during sessions, which of course may further discourage inmates from engaging in much-needed ventilation and discussion of issues. This intricate and sometimes confusing mix of legal, psychiatric, and ethical issues may further discourage prison psychiatrists who are unsure of whose best interests are being served: those of the inmate, the correctional facility, or society at large.

The prevalence of negative countertransference when working with inmates may be especially vexing. Countertransference reactions have been described in work with violent patients.¹⁹ General psychiatrists who have been trained to explore transference issues may find they spend much more time in the prison involved in limiting such contact with inmates, encouraging premature closure of feelings, and generally discouraging the development of transference issues. Psychiatric psychotherapists trained to be empathic may feel overwhelmed and impotent when dealing with inmates serving extended sentences. The existential dilemma of incarceration itself may stymie the psychiatrist, leading him to view his efforts pessimistically, this situation in some ways analogous to the medical profession's previous avoidance of the terminally ill patient, that is "What's the use?"

Medications

The general psychiatrist within the prison will be bombarded with requests for medications, especially sedative-hypnotics and benzodiazepines. While these requests are understandable given the stress associated with incarceration, the use of such medications is not always clinically indicated or symptomatically warranted, and the prison psychiatrist may be easily discouraged by the amount of time spent in dissuading inmates from taking medications not clinically indicated. The prison psychiatrist may find himself routinely complying with inmates' requests as it is the path of least resistance and can be superficially justified on the basis of easing "existential pain." The clinical pitfalls in this approach should be obvious. Likewise, the prison psychiatrist may find himself over-prescribing antipsychotic medications in an attempt to control problematic inmates. While the

limited use of low dose PRN antipsychotic medication for aggressive, impulse-ridden inmates with borderline character pathology is often indicated, its routine use or overuse may signal countertransference issues. Also, with reference to prescribing medication, the prison psychiatrist must be aware of his own feelings of omnipotence, which may be excessively stimulated by the inmates' perception of the physician as all-powerful, especially with regard to control over much-desired medication.

The pessimism experienced within the prison by the psychiatrist may be augmented by the nature of the patients he is treating. It has been suggested that those prison inmates with mental illness as a group are characterized by "general psychosocial disorganization."¹⁹ The deinstitutionalized mentally ill who are at greatest risk to enter the criminal justice system are characterized by their inability to work, their inability to maintain social relationships and family supports, and their resistance to treatment, especially compliance with maintenance medication.²⁰ Thus, the prison psychiatrist may see on a daily basis a concentration of highly impaired, poorly motivated, often chronically symptomatic and acting-out patients with poor premorbid and family histories, limited community and family resources, and poor or absent object relations. This patient population can further stimulate feelings of therapeutic pessimism and negativity on the part of the psychiatrist. The prison psychiatrist's work also may be disturbed by the movement of inmates in and out of facilities due to transfers, releases, and extraditions, which seemingly occur without regard to ongoing treatment. This may further stimulate the psychiatrist's feelings of doubt regarding the importance of his therapy within the prison walls.

A further difficulty for the general psychiatrist within the prison results from the lack of available psychiatric inpatient facilities for acutely disturbed inmates requiring hospitalization. Certain prisons have hospital wings, usually outdated and understaffed, while most others rely on nearby state hospitals, which may not have forensic units. State hospital admission policies may restrict admissions to those inmates who are involuntarily committed so that certain psychotic inmates agreeable to and requiring voluntary hospitalization may not be easily transferred to overcrowded state forensic facilities. Regarding hospitalization of inmates, a further complication for the prison psychiatrist is presented by the suicidal inmate who, while prone to self-mutilatory behavior, may be consciously manipulating for transfer to hospital from prison. Although limit setting by correctional staff may be necessary, it is best for the psychiatrist to base his decision to hospitalize not on the presence or absence of conscious manipulation but on the severity of the inmate's symptoms, the degree of impulse control, and the suicidal risk involved.

The above paragraphs have describe some of the difficulties encountered by the traditionally oriented general psychiatrist working within the prison system. The stressful nature of the prison environment itself, coupled with the limited resources available and the prevalence and severity of psychopathology found therein, has acted to discourage psychiatrists from work within the prison system.

Need for Services

There is no doubt a need for psychiatric services exists within our nation's jails and prisons. Kaufman has suggested that "at the very least, every prison of 500-1,000 inmates should have a full-time psychiatrist, a PhD psychologist, and a multidisciplinary team."² The prevalence of acute psychiatric symptomatology within jails and prisons is marked, and restrictive changes with regard to civil commitment of the mentally ill, coupled with the demise of the state hospital system and the emphasis on deinstitutionalization of the mentally ill, guarantee a continuing, if not increasing, need for psychiatrists within the prison system. The prominence of sociopathy and other forms of chronic character pathology within inmate populations in no way minimizes the need for ongoing psychiatric services as withdrawal and intoxication states, reactive psychoses, severe adjustment disorders, self-mutilatory behaviors, suicide attempts, and psychotic disorders abound. County facilities may have a higher incidence of acute psychiatric pathology; however, such problems occur in all correctional facilities.

General psychiatrists working within the prison will find it necessary to modify their approach in order to maximize their effectiveness, limit counterproductive negative transference reactions, and avoid unnecessary conflicts with nonmedical prison staff. The prison psychiatrist also must be alert to the possible development of "burnout" within himself and other staff members. A crisis-oriented approach that emphasizes brief, time-limited interventions with clearly defined goals for treatment focusing on reduction of acute symptomatology and adjustment to surrounding reality is generally most appropriate. Whenever possible (especially in facilities with relatively stable inmate populations) group therapy techniques should be employed. The use of group therapy not only extends the individual physician's effectiveness but also acts to reduce resistance to treatment that can be experienced in ongoing, one-to-one sessions with inmates. The confrontive approach at times taken by inmates during group sessions may be more acceptable when coming from a peer rather than from an identified authority figure.

The concept of a treatment team is most desirable in prison work. Additional treating staff allows sharing the therapeutic burden of a problematic patient population and enhances treatment by providing on-site peer supervision for clinical staff. The ability to share, discuss, and ventilate about problematic inmates reduces staff burnout. Also, the presence of a treatment team allows the staff, if they so choose, to split treatment and forensic issues, thus avoiding possible conflicts of interest. For example, one member of the staff may be treating an inmate while another staff member carries out a forensic evaluation, with the inmate himself clear on this division. Although somewhat artificial, this approach may allow for treatment of problematic inmates who, while requiring attention, would otherwise be unwilling to seek treatment. It is important that inmates be informed when clinical material is being gathered for a forensic evaluation. In some instances, this approach may enhance the inmate's compliance because his perception of being given a choice (in prison few choices exist) of how open he should be is positive.

The general psychiatrist will find that when possible, in-service educational programs involving nursing staff (if present), prison counselors, case workers, and correctional staff are beneficial. These sessions will improve communication between the prison's correctional staff and the psychiatric treatment team; they act to improve the psychiatrist's understanding of the prison system and also address any mental health concerns (some related to job stress) of the correctional staff. These meetings are helpful in the discussion and management of problematic inmates who act out aggressively against others and who require limit setting within the prison. In this way, authority, control, "rules-and-regulations" issues are handled by nontreating staff (who may suspend privileges, change housing arrangements, or recommend more restrictive handling of inmates). The psychiatrist should be aware of such events and will work with the inmate to help him control his own behavior while acknowledging to the inmate the consequences of such behavior. This approach uses a clearly defined split between treatment issues and authority issues, in some ways analogous to the inpatient management of acting-out adolescents where regulations and restrictions are not carried out by the treating physician himself, but are implemented with his knowledge and direction. Such an approach, however, requires ongoing communication between treatment and correctional staff, which may be facilitated by regularly scheduled meetings.

Psychiatrists' Needs

The mental health needs of the psychiatrist working in the prison setting must be recognized and addressed. When working in such surroundings, the psychiatrist may feel overwhelmed and impotent. He may feel his efforts are futile and he is unable to make any real impact within the system. Recognition of the critical need for and importance of psychiatric services within jails and prisons should not be overlooked. The psychiatrist may rightly view this population as the neediest of the needy — problematic, disturbing, severely limited in resources, but suffering, dysfunctional human beings nonetheless. The presence of colleagues within the prison is of great benefit; PhD psychologists with forensic training are often invaluable members of any such treatment team. In addition, if possible, the general psychiatrist should balance his prison work with outside employment in a private office, community mental health center, or academic position that will provide the psychiatrist with a more balanced patient population. The psychiatrist may seek to establish and strengthen ties between the jail and local community mental health centers. A jail may be viewed as "a community agency that deals with large numbers of community residents."²¹ This view of the jail as a community institution applies especially to county facilities where every effort should be made to establish active liaisons with community mental health centers and their allied programs. Finally, the profession of psychiatry itself should address this continuing and critical need for psychiatric services within our nation's jails and prisons through the teaching and training of general psychiatrists; by the setting and governing of professional standards of acceptable psychiatric care within prisons; and by educating the public, correctional specialists, and legislative and funding bodies about this ever-growing need.

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