American Forensic Psychiatrists Who Work in State Institutions

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The authors surveyed a sample of American forensic psychiatrists who work in state institutions. As a group, their respondents tended to be middle-aged, white men, who had little formal training in forensic psychiatry, felt somewhat alienated from their peers, yet who were Board certified in general psychiatry. They tended to be involved primarily in the direct treatment of patients, and most often expressed concerns about the care-and prominent lack of aftercare—received by forensic patients. They also perceived a sense of patient futility in the institutional forensic setting. The authors conclude by recommending that AAPL take a more active role in appealing to and representing such forensic psychiatrists.

Forensic psychiatrists have come to occupy a highly visible role in contemporary mental health. Although they now interact with numerous areas of the law,[1,2] it has been argued that modern forensic psychiatry's roots are in institutions.[3] One recent study[4] estimated that at least 90 percent of the pretrial psychiatric evaluations concerning competency to stand trial and criminal responsibility performed in Missouri were conducted in state institutions. A nationwide survey of state mental health forensic directors revealed that over half of the states still use state hospitals for evaluations of competency to proceed, and over half the evaluations are performed in such facilities. This strongly suggests that at least one type of forensic psychiatry—that dealing with criminal defendants—remains highly concentrated in institutional settings.

Considering these observations, the authors were quite surprised to find little quantitative knowledge about forensic psychiatrists, their attributes, problems, and practices reported in the literature. Dietz[6] mailed a 10-page 50 item questionnaire to each of the 600 American Psychiatric Association members in Maryland, with mail follow-up to initial nonrespondents. His instrument asked basic information about demographic characteristics, areas of psychiatric subspecialization, training, practice settings,

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professional activities, patient population, attitudes toward patients and their profession, relative use of treatments, and relative referral for treatment during 1974. Using this information, he was able to classify 409 of the 482 respondents as either forensic (42 subjects) or nonforensic psychiatrists (367 subjects.

Dietz[6] found that forensic psychiatrists were significantly younger (41.6 versus 45.0 years) and had a significantly lower proportion of practitioners who had psychoanalytic training. He also observed that 35.7 percent of the forensic psychiatrists, but only 16.1 percent of the nonforensic psychiatrists, reported practicing in state hospitals, a significant difference. Dietz's forensic psychiatrists also engaged in significantly more administrative duties (76.2 percent versus 52.0 percent) in their practices.

His forensic psychiatrists less often practiced intensive psychotherapy or psychoanalysis, and more often practiced pharmacotherapy. Complementing that finding, the forensic psychiatrists also reported their patients to be of lower social class, and to be less sophisticated about psychotherapy and pharmacotherapy. The forensic psychiatrists believed that experience was less important as a factor in quality patient care.

In his discussion, Dietz[6] attributed these differences to the observation that most of the forensic psychiatrist worked in correctional institutions (presumably including state mental and maximum security hospitals) with their associated staffing shortages, undesirable work settings, and highly selected patient populations.

Hanson *et al.*[7] reported results from a 1978–1979 NIMH sponsored survey of forensic psychiatrists in the United States. They asked deans of 163 law schools and 136 university hospital based psychiatry departments to suggest names of forensic psychiatrists, identifying 300 potential respondents to whom questionnaires were mailed. They also surveyed 618 members of the American Academy of Psychiatry and the Law (AAPL), 24 teachers of legal medicine noted in the *Law Teachers Guide* and 39 members in the Section on Psychiatry of the American Academy of Legal Medicine. They received 293 returns, representing 20.2 percent of their 1,450 questionnaires.

Their respondents had a mean age of 47 years, 92 percent claimed "non-minority" status, and 96.5 percent were male. Ninety percent cited personal study and experience as their only sources of training in forensic psychiatry.

Although 75 percent indicated they engaged in court-related evaluations, diagnosis, and testimony, and 72 percent consulted with patients' attorneys, they reported practicing "forensic Psychiatry" only 37 percent of their professional time. Only 26 percent identified themselves as specialists in forensic psychiatry. Sixty four percent were involved in teaching, and 38 percent engaged in administration.

The authors clearly indicated that their sample population might be "biased in the direction of academically involved and full-time forensic psychiatrists." Unfortunately, Hanson *et al.*[7] did

not report the practice sites of their respondents, therefore, we do not know the extent to which those who practice in forensic institutions were included in the sample. A subsequent survey[8] of 850 AAPL members—48 percent of whom responded—found that "nearly two-thirds spent at least 60 percent of their forensic time in civil practice as opposed to criminal. . .," thus suggesting that a major portion of Hanson *et al.*'s[7] population may have been relatively less involved in institutional practice.

As the preceding paragraphs suggest, we have precious little quantitative information about those forensic psychiatrists who practice in institutions despite their major contribution to the profession. Thus, the AAPL Committees on Institutional Forensic Psychiatry and Education, supported by the AAPL Executive Committee, decided to survey American institutional forensic psychiatrists during 1987. It was hoped that this effort would yield basic descriptive information about such psychiatrists, their practices and concerns, with the hope that the Academy could better address their needs.

Methods

The authors and members of the AAPL Committee on Institutional Forensic Psychiatry developed a 32 item five and one half page questionnaire for mail distribution. This questionnaire inquired about: demographics; aspects of professional practice; the respondent's relationships with courts, attorneys, other mental health practitioners, administration, and the legislature; confidentiality; working conditions; issues relevant to recruitment and retention of psychiatrists; research; and patient admission, treatment, and release.

We mailed a request to each state's respective Director of Forensic Services for the names of all psychiatrists who worked in each state's forensic facilities. Replies were received from 26 states, with 410 names being made available for survey distribution. The AAPL Central Office in Baltimore mailed the surveys to each of the so identified institutional forensic psychiatrists, and we received 107 (26%) replies. Because this was a preliminary study, with the prospect of more detailed follow-up through the Membership and other AAPL Committees, we chose not to pursue non-respondents with repeated mailings or telephone contacts. Therefore, the questionnaires were not identifiable by subject in any way. Our response rate suggests that respondents may have represented those institutional forensic psychiatrists who were most likely to be interested in participation in professional organizations such as AAPL.

No attempts were made at statistical comparison since this was simply a descriptive investigation. However, we considered a problem area as likely to be important if it was endorsed by at least 33 percent of our respondents. This proportion was selected because we thought anything smaller would be difficult to interpret in the context of our comparatively low response rate.

Results

The mean age of our respondents was 52 years. Eighty-one percent were married, and 90 percent were male. Seventy-

six percent were white, 13 percent oriental, seven percent black, and six percent did not disclose their ethnic group membership. Ninety-six percent of our respondents had MD degrees, whereas three percent had PhDs, and two percent each had DO or MPH degrees. Although we only surveyed physicians, two percent of our sample did not indicate whether they had an MD or DO degree. Sixty-eight percent were certified in psychiatry by the American Board of Psychiatry and Neurology, but only 8 percent were certified by the American Board of Forensic Psychiatry. Seventy-one percent were members of the American Psychiatric Association. We identified 55 (13.4%) of our sample as being AAPL members by checking them against the AAPL Membership Directory. However, 27 (25%) of our respondents identified themselves as AAPL members.

Although the great majority of respondents had presumably completed general psychiatry residency training, only 5.6 percent had completed a forensic psychiatry fellowship. Our respondents had practiced forensic psychiatry for a mean of 10.7 years, and were working an average of 30.4 hours weekly in institutions at the time of the survey. Forty-eight percent worked in state hospitals, 34 percent in security hospitals, and 15 percent in prisons, jails, or both. Eighty-nine percent of these people considered their identity to be that of a practitioner who worked on the "front lines".

The division of labor reported by our institutional forensic psychiatrists is reported in Tables 1 and 2. Table 1 shows the percentages of our respondents who engage in various activities, whereas Table 2 indicates the percentages of their professional time devoted to different types of activities. Major problems with their practices which were cited by our respondents are listed in Table 3. What clearly emerges is that most respondents have very diffuse roles, performing most professional activities. However, most of their time is occupied with treatment, assessment, and administration. Less than 10 percent of their time is involved in writing reports, consulting others, monitoring medical records, testifying in court, teaching, research, or authorship.

Table 1
Percentage of Institutional Forensic Psychiatrists Who Perform Various Activities

	Percentage
Treatment	82
Assessment	72
Testifying	68
Consulting others	63
Writing reports	61
Administration	57
Medical records	51
Teaching	46
Research	13
Authorship	8

Table 2
Percentage of Institutional Forensic Psychiatrists' Time Devoted to Various Activities

	Percentage
Treatment	28
Assessment	21
Administration	15
Writing Reports	8
Consulting Others	6
Medical Records	6
Testifying	6
Teaching	5
Research	1
Authorship	1

Table 3
Most Frequent Work-related Problems

	Percentage
Interprofessional	
Lack of understanding of clinical problems by legislators	50
Power struggles with institutional psychologists	40
Lack of understanding of clinical issues by administrators	34
Work conditions	
Low pay	54
Inadequate workspace	47
Inadequate travel to meetings	41
Poor climate control	41
Overwork	40
Poor noise control	38
Poor staff morale	36
Inadequate resources for research	33
Patient care	
Patient refusal of treatment	57
Inadequate aftercare	50
Patient feelings that treatment is futile	41
Inappropriate judicial commitments of patients	40

Of the 82 percent who reported providing any treatment at all, 86 percent prescribed medications, 85 percent participated in treatment team meetings and planning, 58 percent provided individual psychotherapy, 30 percent conducted group therapy, and seven percent provided unspecified treatment.

Discussion

We have attempted to develop an initial survey description of American Forensic psychiatrists who work in state institutions. The low response rate to our questionnaire, although comparable to some previous studies, is of concern for two reasons. First, it clearly limits the ability to generalize from our data and conclusions because respondents are unlikely to represent a random sample of the population of institutional forensic psychiatrists. Second, and perhaps more troubling, that only slightly more than half of the state forensic program directors responded to our initial request for information suggests there is little support at the administrative level in many states for activities that are not perceived to be directly job-related.

It may be possible to infer from our findings why our response rate was so low. Similar to two earlier studies,[6,7] we found our respondents were overwhelmingly white, middle-aged men, two-thirds of whom were certified in general psychiatry. However, we found evidence suggesting our entire study group had little interest in organized forensic psychiatry: few had received formal training or certification in forensic psychiatry; and although 25 percent of our respondents identified themselves as AAPL members, only 13.4 percent of our entire survey population were identifiable as AAPL members. Our respondents tended to perceive legislators and administrators as lacking understanding of clinical issues, they felt overworked, and

that they had both inadequate travel to professional meetings and insufficient resources for research. All these factors lead us to conclude our response rate may have been low because of administrative non-support, an overall low interest in organized forensic psychiatry, and feelings of being overburdened and isolated among our target population.

We thought it interesting that our respondents had practiced forensic psychiatry a mean of 10.7 years. If we note our subjects' mean age as 52 years, and assume they generally completed their formal psychiatric training by around age 30, then we can speculate that it is likely that they practiced other types of psychiatry before forensic psychiatry. This could indicate some vocational instability perhaps due to job dissatisfaction (which could have also contributed to our low response rate) Conversely, it could indicate increasing satisfaction leading to subspecialization within psychiatry. There may be other interpretations, as well.

Additionally, our subjects were mostly involved in the diagnosis and treatment of the mentally ill despite having diffuse professional responsibilities. This suggests that forensic psychiatry as practiced in institutions is weighted toward primary care.

Our respondents believed that administrators and state legislators remain relatively uninformed about the unique needs of forensic patients and those who treat them. In states more attuned to those needs, the degree of facility, departmental, and legislative cooperation can be outstanding. For example, the Wisconsin Legislature has enacted exemptions to the statute governing patient rights in an attempt to meet some specific environmental and treatment needs of patients and staff in the state's maximum security facility.[9]

Such beliefs and experiences have given rise to the State Mental Health Forensic Directors (SMHFD) as part of the National Association of State Mental Health Program Directors (NASMHPD). One of SMHFD's goals was to increase the various state governments' awareness of issues relevant to the management of forensic patients. Through such efforts, SMHFD has been instrumental in liberating financial and political resources that have permitted the upgrading and subsequent JCAHO accreditation of several forensic facilities. In addition, SMHFD has lobbied for improved salaries and legislative changes to improve the admissions, transfers, and discharges of forensic patients.

Unfortunately, SMHFD's membership is restricted to state-level forensic directors (i.e., middle-level administrators). Although others, including frontlines forensic psychiatrists, may attend SMHFD's annual meetings, forensic psychiatrists *per se* do not have direct representation in SMHFD. We think AAPL should reach out to these colleagues and offer them a more direct voice in the dealings of their profession.

Our subjects voiced legitimate concern about their employment conditions. Many state institutions are old, of poor design, and not air-conditioned. The numbers of available staff are often

insufficient, recruitment is difficult, and vacant positions remained unfilled for long periods. There tend to be fewer perquisites than had in university or private practice jobs.

One solution may be to encourage affiliation with academic departments of psychiatry, which was found to be one major source of job satisfaction expressed in a 1978 survey of general psychiatrists.[10] As examples, Maryland,[11] Massachusetts,[12] Missouri, and North Carolina have established such affiliations by requiring residents to rotate through state facilities. This can mutually enrich the state facilities (e.g., by enhancing recruitment, continuing education, and institutional prestige) and their associated academic departments (e.g., by broadening clinical experiences, and stimulating teaching and research).

It is disquieting that our respondents perceived tensions to exist between themselves and their institutional psychologists colleagues. Such perceptions likely reflect the escalating national conflict between psychiatrists and psychologist, but also the tensions inherent in attempting to work and treat patients within security facilities.

We thought it interesting that our subjects did not complain about malpractice or other legal liability. We are inclined to believe that more torts in this area are filed against state departments of mental health, naming long lists of defendants rather than targeting single practitioners. In this scenario, a state forensic psychiatrist would be seen as just another team player, having pockets no deeper than any other. Additionally, such forensic psychiatrists might practice under sovereign immunity[13] or with responsibilities and authorities explicitly granted by state laws.

Our respondents' perceptions about patient care concerned us. Patient refusal of treatment was seen as problematic, yet our subjects did not believe they were endangered at work. This leads us to speculate that treatment refusal aroused more compassionate concerns about continued human suffering and sickness rather than a fear of harm among our sample of forensic psychiatrists. It is also possible that our respondents had less direct or frequent contact with their patients than did line staff, thus perhaps accounting for our findings of a relative less concern for personal safety.

We were more alarmed by the perceived lack of aftercare provided forensic patients. Forensic patients are among the most difficult, frustrating, and challenging of any patients. They often have multiple diagnoses including psychoses or affective disorders, complicated by substance abuse and personality disorders. They act out frequently, often requiring heightened degrees of structure and supervision. They are sometimes resentful of or uncooperative with medications or other treatments.[14] Some are refractory to treatment. They frequently lack supportive family or friends, jobs, or other opportunities upon release. In addition, many community mental health facilities are very reluctant to accept the responsibility of treating and supervising such patients. We believe it is unconscionable to release such poten-

tially volatile patients from secure hospitals to inadequate outpatient treatment and follow-up.

Equally as alarming as the lack of aftercare was the perception that patients tended to feel they were "doing time" rather than participating in their treatment actively. It is certainly the case that nonsymptomatic forensic patients may be held in the hospital for other than clinical reasons, which could lead to feelings of futility among patients. Treatment of such patients clearly takes on a different meaning than treatment to relieve the suffering of the mentally ill.

A recent paper discusses several major relevant areas in dealing with such patients.[15] These areas include novel approaches to enhancing administrative coordinations, variations in the timing or locations or providing treatment, and countertransference issues. Although it is not possible for us to detail these issues here, it has become apparent that forensic psychiatrists who work in institutions are searching for creative approaches to treating their patients.

We hope this work has contributed in some small way to knowledge about institutional forensic psychiatrists in America. We also hope it stimulates much more thoughtful discussion within the profession, and will serve as a departure point for future investigations and action, both to improve the working conditions of institutional forensic psychiatrists, and, more importantly, the quality of care provided to forensic patients. We recommend that AAPL encourage our colleagues who work in institutional settings to join our ranks, participate in our meetings, and add to our voices.

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