

# Description of an Outpatient Psychiatric Population in a Youthful Offender's Prison

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Prisons are receiving increased numbers of inmates with mental and emotional problems. This study describes some of the characteristics and treatment of such an outpatient population. It was determined that a typical patient is a white male, 19 years old, of average intelligence, with a sporadic work record and poor academic performance, who quits high school in his freshman year. He has a history of substance abuse and is likely to have a multidrug habit. He is likely to have had a traumatic childhood and had psychiatric treatment as a child or young adolescent, as well as having attended special classes in school and counseling for drug abuse. The great majority of patients were diagnosed as having either mood, adjustment, or psychotic disorders. All were treated with a psychotropic medication and case management and also with some type of accepted individual and/or group counseling. In this population, there is a high incidence of expression of aggression requiring medication and counseling with the patient's permission. Patients responded well to treatment, but usually requested to discontinue treatment when symptoms diminished. However, approximately half of them returned for medication when symptoms recurred.

The incidence of crime and incarceration is increasing rapidly in the United States.<sup>1</sup> For instance, the number of persons in U.S. prisons has risen 188 percent over a 13-year period to a high of 948,881 in 1993.<sup>2</sup> Incarceration for serious crimes such as sexual assault, robbery, aggravated assault, and burglary rose 34 per-

cent between 1980 and 1992.<sup>2</sup> Patients in corrections facilities have similar psychopathology to those in psychiatric hospitals;<sup>3</sup> the diagnosis of psychotic disorders has been reported as more likely to be made with black than white patients.<sup>4</sup>

Along with the large influx of regular inmates, prisons are also experiencing an increase in the numbers of individuals with mental and emotional problems, variably described as comprising between 24 percent<sup>5</sup> and 76 percent<sup>6</sup> of the prison population. Due, in part, to deinstitutionalization in the 1960s and 1970s, mentally ill individuals are now often placed in prison when they commit a crime

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rather than housed in a mental institution. This fact, coupled with recent court cases that have defined constitutional requirements for basic health care, means that prisons by default have become prime containment facilities for many people with mental and emotional problems.

These conditions set up a number of dilemmas for correctional institutions. Prison officials have traditionally viewed psychotherapy as being outside the mission of the institution, and resources and personnel are generally ill-equipped and too overwhelmed by other needs to provide mental health services to inmates.<sup>7</sup> Even more important, in an era of downsizing government and public expenditures, there are increasing budgetary limitations on mental health provisions.

These constraints mean that it is extremely important for prison officials to be able to identify potential consumers of mental health services, to maximize both services and budgets. There are considerable impediments to this identification process, not the least being that there is a lack of available information on just how many inmates experience some form of psychiatric disability.<sup>5</sup>

Changes are occurring in the practice of medicine in prisons. It has become common to provide psychotropic medication to prisons inmates in the United States and Europe,<sup>8-11, 17</sup> provided that the inmates consent to such treatment.

This article reports on observations made and treatment provided for 150 prisoners who received psychiatric intervention on an outpatient basis in a prison for youthful offenders (age range, 14 to 24 years). All of these inmates, including

the minors (20% of the patients), had been tried and convicted in an adult court. A comparison of this group of inmates with 150 controls is the subject of another study.<sup>13</sup>

## Methods

What this survey measures and how it was conducted was based on several factors. Approximately 150 subjects were categorized as S-III (that is, they had been interviewed by a psychiatrist), either at reception centers before receiving permanent placement or after placement at this youthful offender prison. Approximately 40 percent of them were changed to S-III status after this placement. All of these inmates were given subsequent mental status exams on one- to four-week intervals. Changes in S-status were made when indicated by mental status.

The survey institution is a medium security prison. Inmates in the S-I category have no significant impairment, due to an Axis I disorder, in their ability to adjust to the institution. Those in the S-II category are considered to have mild impairment in adaptive functioning (associated with Axis I disorders) within general inmate housing. They are provided with case management and counseling. An Axis III diagnosis denotes moderate impairment due to an Axis I disorder. These inmates are given case management counseling and psychiatric consultation, with at least periodic administration of psychotropic medication. Referrals are made to psychiatrists by psychologists. Those in the S-IV category are severely impaired and are assigned to inpatient mental health care. In our facility, the distribution of

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those categories varies but currently is 86 percent S-I and approximately 7 percent S-II and 7 percent S-III. There is no S-IV category at this institution because there is no inpatient unit. The S-III category diagnosis is given only by a psychiatrist, either at a reception center or after the inmate receives permanent placement; that category may be changed to S-II by a psychiatrist if no further psychiatric treatment is necessary.

Because of time and financial constraints, we used some of the data that had already been gathered in a screening process by mental health staff at the prison reception centers. Specifically, these data fell into four main categories: demographic information (age, sex, and race), criminal background, social history (employment, substance abuse and treatment, educational level, and use of special school services), and prior psychiatric measures of functioning and symptomatology (IQ,<sup>14</sup> Beck hopelessness testing,<sup>15</sup> family and personal histories, and past diagnosis(es)). We supplemented this information with a psychiatric diagnostic interview performed by both a psychiatrist and a psychologist. Our rationale for conducting the survey in this manner was threefold: (1) we could confirm or reject past diagnoses; (2) we could, with reasonable ease, verify information in the chart; and (3) we could obtain a psychiatric and social history to facilitate the understanding and treatment of the individual.

We developed a profile to record data on each of the 150 subjects. This profile recorded age, sex, race, offense, Beta IQ score, hopelessness score, family history

of mental instability, personal history of psychiatric in/outpatient care, previous use of psychotropic medication, past diagnosis(es), substance abuse and treatment history, employment background, educational achievement, and use of special education classes. It should be noted that initial IQ scores were found using the Beta IIR; when scores were below 70, the Wechsler Adult Intelligence Scale (WAIS-R) was given to determine the intelligence level more precisely. The profile did not discriminate between learning disabilities (LD) and emotionally handicapped (EH) in recording a special education background.

Patient confidentiality was maintained during the study. Each of the subjects was assigned a number between 1 and 150, thereby insuring that no inmate could be identified from the written records, while at the same time making it possible to match data and to add further information as it became available.

Our sample consisted of a survey of all S-III inmates who arrived for placement as well as of those changed to S-III status after transfer to this institution over a 22-month period of time. It was necessary to include all S-III inmates so that we could provide ourselves with a large enough study sample. This gave us a rather heterogeneous population, which was controlled through four variables; members in the population: (1) met the definition of an S-III diagnosis; (2) had been sentenced to a minimum to medium security level institution; (3) were male; (4) were between 14 and 24 years of age.

All of these inmates were evaluated by the same psychiatrist and psychologist.

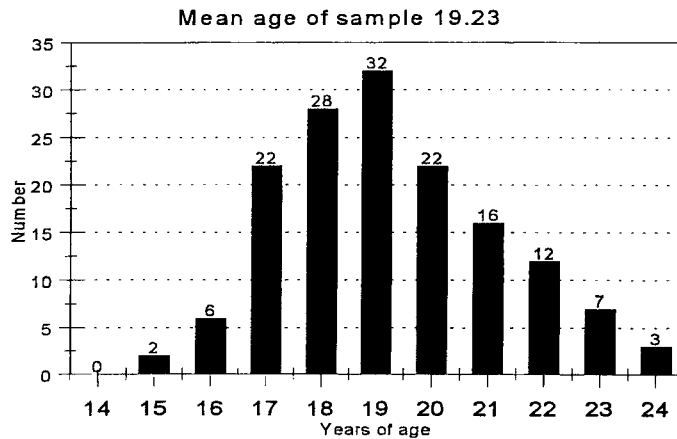


Figure 1. Age distribution of subjects.

Diagnoses were made on the basis of the clinical interviews, using the criteria listed in the DSM-III-R.<sup>16</sup> Patients were interviewed and treatment provided at one- to four-week intervals.

### Results

The age range of our population is reported in Figure 1. While all ages except 14 years old are represented in the sample, the greatest concentration fell between ages 17 and 20 years and formed a normal distribution pattern. The mean age of the sample was 19.23 years.

Racial mix is illustrated in Figure 2. There was almost a three to one ratio of white to black inmates in the sample. Only two percent of the inmates included in the sample were neither white nor black; these were classified as "other." The racial distribution of the total prison population varied from week to week because of turnover during the period of this study. The current count at the time of this writing is 48.7 percent white, black 50.8 percent, and .5 percent other of a

total of 896 inmates with a varying distribution of S-I, S-II, and S-III categories only.

The highest grade level achieved by members in the sample is the focus of Figure 3. As with age, the set data appeared to form a normal distribution

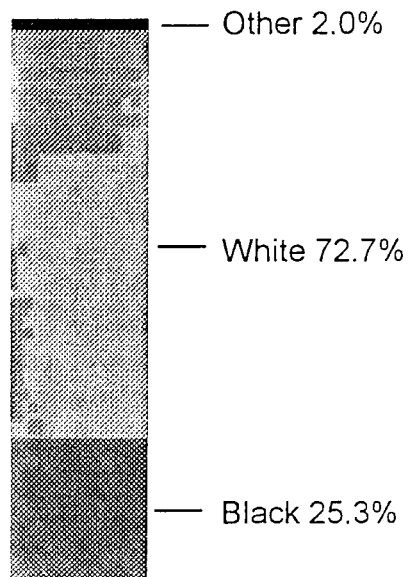


Figure 2. Racial distribution of sample.

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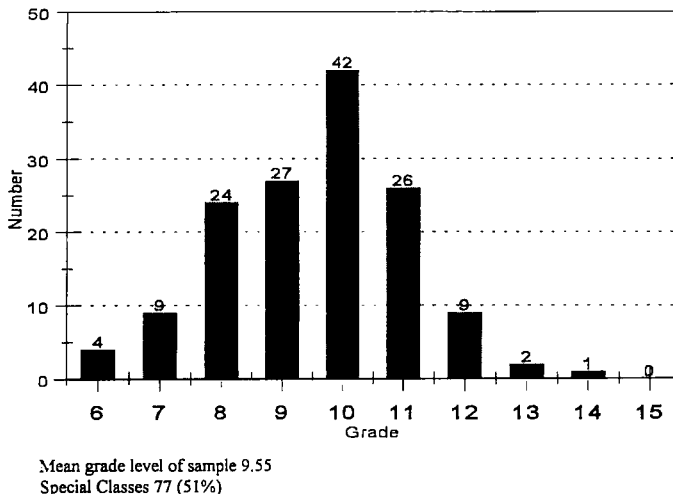


Figure 3. Distribution of sample by grade.

curve when graphed. The mean grade level achieved by the sample was 9.55 years of school. Seventy-seven of one hundred fifty participants reported a history of special education placement.

Substance abuse data are reported in Figure 4; 87 percent of inmates in the study admitted to some form of drug or alcohol abuse. The most widely used drug was marijuana (69.3%), while alcohol ran a close second (66%). Almost two-thirds of the sample reported a multisubstance abuse problem. Twenty individuals

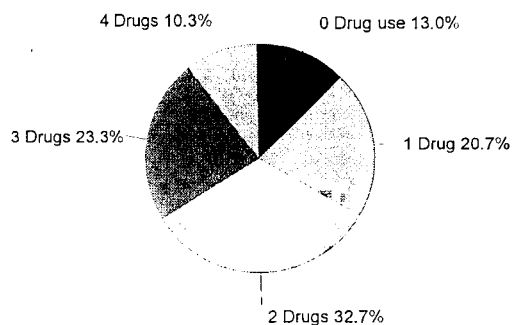


Figure 4. Distribution of sample in substance abuse.

(13%) denied using any drug or alcohol; interestingly, this subgroup was composed of nine black inmates, or 23.2 percent of the total black sample, and eleven white inmates, or 10.2 percent of the white sample (Figure 5).

Figure 6 illustrates work performance data for the members of the study prior to their incarceration. The top cell reports the average number of months of a total 36 that an inmate in the study worked; the middle cell is the average number of jobs held in the 36-month time period; and the bottom cell records the average number of months an S-III inmate in the study was able to keep the same job.

Table 1 lists the diagnostic categories into which the inmates in the study were divided. Approximately one-third of the sample were diagnosed with mood disorders (major depression, depressive disorder not otherwise specified (NOS), dysthymia or bipolar disorder). The second largest group was made up of those diag-

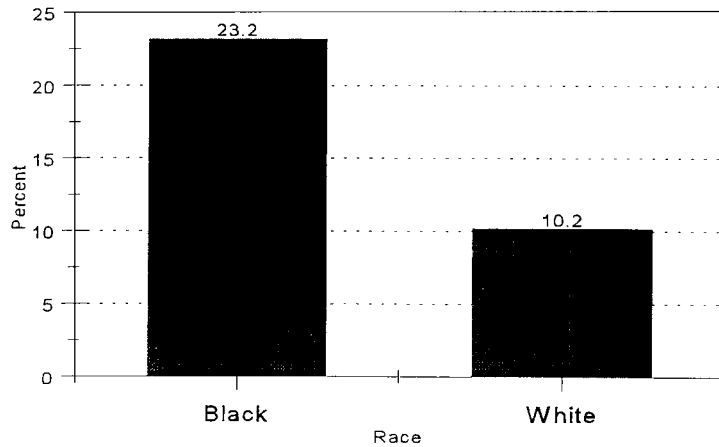


Figure 5. Racial distribution of sample denying any drug/alcohol use.

nosed with adjustment disorders, while psychotic disorders (psychosis NOS and schizophrenia) was third; these three categories accounted for almost 87 percent of the inmate diagnoses in the study.

Scores of nine or higher on the Beck hopelessness test<sup>15</sup> indicate a high degree of pessimism toward the future and suggest a higher potential for suicide. Of the sample, 30 of the 150 inmates had scores of nine or higher.

Overall, the mean IQ of the sample was 92.12, as measured by the Beta IIR (14), which is in the average range of performance.

Table 2 records family data and personal history of psychiatric treatment. In this sample, for instance, 54 inmates (36%) reported a family history of psychological problems. Seventy subjects (46.7%) stated that they had been hospitalized at least once before prison; 92 (61.3%) claimed prior outpatient treatment, and 85 (56.7%) admitted to receiving psychotropic medication before incarceration.

By definition, all S-III inmates had been treated with psychotropic medicines (i.e., they were given S-III status usually at the time medicine was prescribed by a psychiatrist). The target symptoms of the S-III inmates were usually depression, anxiety, aggression, impulsivity, or hallucinations. A wide variety of antidepressants were available. It was not unusual for different types of antidepressants to be tried with the same patient before an ef-

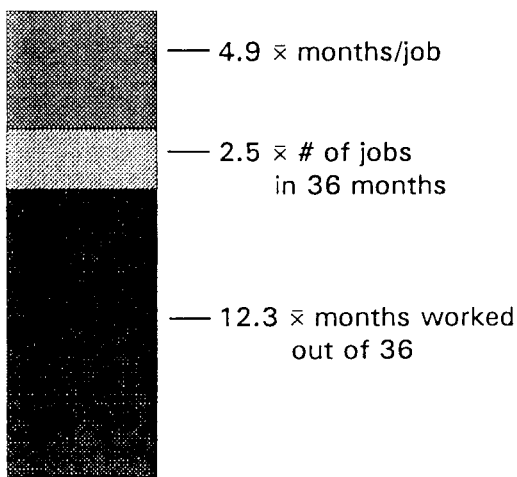


Figure 6. Work performance for S-III inmates.

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**Table 1  
Diagnoses Made on S-III Inmates**

|               | Diagnosis                                | Total |
|---------------|--|-------|
| Adjustment    | Adjustment disorder with depressed mood  | 24    |
|               | Adjustment disorders (all other types)   | 18    |
| Mood          | Depressive disorder, NOS                 | 14    |
|               | Bipolar disorders                        | 17    |
|               | Major depressive disorders               | 10    |
|               | Major depressive disorder with psychosis | 5     |
|               | Dysthymic disorder                       | 5     |
|               | Schizoaffective disorder                 | 3     |
| Psychosis     | Psychotic disorder, NOS                  | 23    |
|               | Schizophrenia, paranoid type             | 4     |
|               | Schizophrenia, undifferentiated type     | 2     |
| Behavior      | Intermittent explosive disorder          | 8     |
|               | Attention deficit hyperactivity disorder | 2     |
|               | Conduct disorder                         | 1     |
|               | Impulse control disorder, NOS            | 1     |
| Personality   | Personality disorder, NOS                | 1     |
|               | Schizotypal personality disorder         | 1     |
|               | Panic disorder                           | 2     |
|               | Generalized anxiety disorder             | 4     |
| Miscellaneous | Tourette's disorder                      | 1     |
|               | Polysubstance-related disorder           | 1     |
|               | Deferred                                 | 3     |

NOS, not otherwise specified.

fective one was found to be acceptable by both doctor and patient. Tricyclics and serotonin reuptake inhibitors were found

**Table 2  
Personal and Family Psychiatric History**

|   | S-III | %    |
|---|-------|------|
| Family history                                  | 54    | 36   |
| Prior hospitalizations                          | 70    | 46.7 |
| Prior outpatient treatment                      | 92    | 61.3 |
| Prior psychotropic medications                  | 85    | 56.7 |
| Total S-III with prior psychiatric intervention |       | 79.3 |

to be effective in approximately equal numbers of patients with symptoms of depression. Anxiolytic medications with value as street drugs were avoided as were drugs with potential for habituation (e.g., benzodiazepines and psychostimulants). Therefore, anxiety was treated usually with hydroxyzine.

Aggression and impulsivity were treated, when necessary and with the patient's consent, by a variety of medicines. Clonidine was helpful in approximately one-third of the patients to whom it was given to decrease aggressiveness and im-

pulsivity. Lithium, anticonvulsants, antidepressants and, as a last resort, neuroleptics were used effectively to assist the patients in controlling their aggressiveness. Psychotic symptoms were treated with neuroleptics. Flashbacks and "trails" resulting from previous abuse of hallucinogens were treated only when they were causing great discomfort to a patient.

In all cases, the psychologist provided case management, and in approximately one-half of the cases, he provided individual counseling. Anger, stress management, and problem-solving groups were recommended to many patients and approximately one-third of those to whom it was recommended participated in the groups.

### Discussion

**Age** The mean age of the sample, 19.23 years, is not inconsistent with that of the general population of the study institution. Inmates in the sample fell into a normal distribution curve when graphed, with the greatest concentration between the ages of 17 and 20 years. There were no 14-year-olds in the survey group and only eight individuals who were either 15 or 16. One reason that there were so few in this age category may be the fact that early and mid-teens are not sent to prison unless they have committed such a serious series of crimes that the usual juvenile sanctions are not appropriate. Likewise, a reduction in numbers on the other end of the continuum (10 inmates ages 23 or 24) probably reflects the fact that older inmates are sent to adult prisons rather than to a youthful offender facility.

**Race** There is a disproportionate number of white compared with black inmates in the S-III sample and very little representation of any other racial group; this does not represent the racial mix of the general population of the institution. There may be several explanations for this disparity. It has been postulated that black inmates tend to project the image of being tough and strong; this image may be damaged by dependency on psychotropic medication and counseling and so tends to discourage individuals from coming to a mental health clinic for help. Another reason may be the general consensus among inmates that psychotropic medication "slows" a person down; hence, someone expecting that he may have to defend himself in prison would reject psychiatric help and medication so that he could remain "sharp." A third reason for the large disparity in racial mix may result from the fact that some ethnic groups may perceive the benefits of treatment; while some may have had previous exposure to counseling, other ethnic and racial groups may have used other modes such as family, friends, and religious organizations for help in times of trouble. The same psychological and psychiatric services are provided for all inmates regardless of race. The same procedures for access to care by a psychiatrist are available to all inmates.

**School** The mean grade level that subjects attained in this sample was 9.55 years of school. Although the data approximate a normal distribution, several interesting observations can be made: (1) almost one-quarter of the survey group (24.7%) dropped out of school by the end



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of the eighth grade; (2) only 12 S-III subjects (8.0%) finished high school. The lack of formal education represents an enormous deficit for individuals entering the work force and attempting to compete for jobs with better-educated peers.

Another significant finding was that 77 (51.0%) subjects reported a history of special education classes while in school. While this profile does not categorize LD or EH conditions, it does indicate that many individuals in the sample have been followed and given special education help throughout their childhood and early adolescence.

**Substance Abuse** Eighty-seven percent of the sample reported a substance abuse problem, while 66.3 percent admitted to multidrug use. Over one-third of the sample (36.7%) reported that they had received treatment for drug problems prior to incarceration. One of the questions raised by these data for prison psychiatry is to what extent are we treating drug addicts, individuals with residual symptoms of drug abuse, or people who try to self-medicate?

**Work** S-III inmates in the survey held a job, on the average, for about five months before terminating; altogether, in a 36-month period, the typical subject in the sample worked about one-third of the time (12.3 months), leaving long sections of time idle. While a sporadic work history does not necessarily point to mental or emotional instability, when it is combined with poor school performance, this history begins to focus on a population with a number of deficits that interfere with social integration and success.

**Diagnostic Categories** The 150 sub-

jects in the survey were placed in categories based on their current Axis I DSM III-R diagnoses. By far the largest group was made up of individuals with mood disorders, followed by adjustment and psychotic disorders. Considerable depression was expected in the prison environment. Although precipitating stressors occurred in the prison environment, bad news from home frequently initiated affective and vegetative changes that ultimately resulted in depression.

Adjustment disorders were common and were often related to the stresses of being incarcerated. Our initial impression was that inmates in the S-III population were more sensitive to stress and thus more affected by it than the general prison population. The diagnosis of psychotic disorder NOS was frequently made because the symptoms were not indicative of a more definitive psychosis; for example, there were descriptions of longstanding hallucinations and other psychotic features, along with relatively good reality testing and no established organic cause, and these hallucinations often responded to neuroleptics. Most of the patients were found to have diagnoses of either depressive, psychotic, or adjustment disorders. Based on their criminal record, it was assumed (but no tests were given) that diagnoses such as conduct disorder, oppositional defiant disorder, substance abuse at age 17 or younger, and antisocial personality disorder at age 18 and older would be comorbid with the diagnoses for which they were treated.

One of the problems associated with a survey conducted within a confined population is the possibility of individuals

faking symptoms in order to get out of unpleasant tasks or situations. However, since almost all of the inmates in this study report long histories of psychiatric treatment before entering prison, or report having taken special education classes in school, or admit to drug or alcohol treatment (93.3%), it can be inferred that the percentage of individuals successfully manipulating the system is quite small and that the great majority of S-III inmates in this study have genuine psychiatric disorders. When malingering was suspected, the patient was followed to assess the validity of the individual's complaint. If malingering was confirmed, a note was written including data to support this finding, and no psychiatric treatment was provided.

**Other Observations** Since 20 percent of the total sample had scores of 9 or higher on the Beck hopelessness scale at the time they entered the prison system, these inmates may have been incipiently depressed early in their incarceration.

While IQ scores varied greatly in this sample (63 to 130), the mean was 92.12, which falls in the average range of intellectual functioning.

A sizable percentage (36%) of our sample reported significant dysfunction and trauma in their families of origin during their developmental years, which could have affected their ability to form and maintain meaningful attachments to others as well as having lead to aggressiveness toward others.<sup>17</sup>

Many subjects in the study reported early psychiatric intervention in their lives in the form of hospitalizations, out-

patient therapy, or psychotropic medications (79.3%). While itself not a universal marker for the sample, this history, combined with treatment for drug abuse and special education classes in school, was applicable to more than 90 percent of the individuals surveyed.

The great majority of patients placed on psychotropic medicines responded well, but requested discontinuing their treatment when symptoms were diminished. Approximately half developed recurrent symptoms requiring further treatment. Only a few were willing to accept maintenance medication to prevent recurrence of symptoms.

As we continue to review our findings, we hope to find more correlations in the data that would help mental health personnel make appropriate decisions regarding candidates for psychiatric referral. It is hoped that such information will be helpful in making the screening process more efficient.

The practice of psychiatry in this population was in many ways similar to practice in the community at large. However, there were some differences. There was a much greater incidence of expressed aggression requiring medication to help the inmate control his physical aggressiveness, primarily with other inmates but occasionally with officers also. When the participants learned the extent to which medicine helped them control symptoms, they would request to be on or off medicine as the level of stress and provocation varied. Hopefully, they might get similar help when they return to the community. Similarly, some inmates found

individual counseling or group, goal-directed therapy sessions with psychologists helpful.

This survey opens up a number of directions for further study. Are the results of this study transferable to other prison populations? How does the percentage of psychiatric patients compare with the general population, and is the composite of diagnoses reflective of the population outside of prison? Also, why are minority groups not represented in greater numbers in the S-III sample? To what extent are we facing a social problem consisting of an increasing number of youths with inadequate skills to hold jobs, yet who are able to obtain a perceived "better lifestyle" illegally?

### Conclusions

A typical inmate who is classified S-III in this youthful offender setting is a white male, 19 years old, with a sporadic work record and poor academic performance, of average intelligence, who quit high school during his freshman year. He has a substance abuse history and is likely to have a multidrug habit. He has numerous deficits in educational, vocational, and socialization skills. He is likely to have had a traumatic childhood and had psychiatric treatment as a child or young adolescent, as well as having had special classes in school and counseling for drug abuse. The majority of patients were found to have mood, adjustment, or psychotic disorders. They responded well to psychotropic medicines.

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