Correctional Psychiatry

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A significant amount of forensic psychiatric work occurs with prison populations. The US has one of the highest rates of incarceration among Western societies. According to the Bureau of Justice Statistics, at the end of 2002, 2,166,260 individuals were under the custody of correctional authorities in federal and state prisons, local jails, and military and juvenile facilities. The rate of incarceration was 701 inmates per 100,000 residents, meaning that 1 in every 143 US residents were incarcerated in federal or state prison or a local jail.

There is ample evidence that the incarcerated population is not a representative sample of the US general population. In fact, gender, racial, and socioeconomic differences are present and have been extensively analyzed. In addition to those, significantly elevated rates of mental illness are present in the incarcerated group. The higher prevalence of psychiatric disorders among prisoners and jail inmates was initially described in the mid 1970s. Since then, these findings have been consistently replicated.

The reasons for the increased rates of mental illness among incarcerated individuals are the source of much controversy. Theories that originated in Europe in the early part of the 20th century suggest that societies tend to institutionalize a stable number of individuals, and that an inverse relationship exists between prison and mental hospital populations. There is also evidence supporting the hypothesis that deinstitutionalization and the criminalization of the mentally ill are the culprits for the mentioned

differences. In addition, the punishment of substance abuse, in the form of drugs laws and mandatory sentencing, have resulted in the incarceration of individuals with dual diagnosis who are arrested typically after violations of probation resulting from substance abuse relapses.

Another theory is that changes in civil commitment laws over the past two decades, which added more stringent criteria based on dangerousness rather than on mental illness itself, have resulted in fewer and shorter involuntary hospitalizations. In addition, managed care has also significantly affected the amount of time that these patients spend in inpatient units once admitted. As a result, a large number of mentally ill individuals who do not meet criteria for civil commitment are left in the community, at times unwilling or unable to pursue outpatient treatment, which increases the likelihood of engaging in behavior that could result in incarceration.

While this phenomenon has been studied in the US, other countries have also reported increased rates of mental illness in their prison and jail populations. New Zealand's prison population, for example, has rates of schizophrenia and related disorders that are three times greater than they are in the community for men and four times greater than they are for women. In Canada, rates of schizophrenia were reported at seven times that of the community, with major depression and bipolar disorder at two and four times higher, respectively. In the UK, with a prison population of approximately 70,000, seven percent of the sentenced men and 10 percent of unsentenced inmates were described as suffering from "functional psychosis." A review of rates of mental illness among incarcerated individuals in the western world showed that the rate of psychotic illness and major depression was 2 to 4 times higher than in the community for both men and women. The rates of antisocial personality disorder were also approximately 10 times higher than in the community for both men and women.

In the US, inmates are the only group that has a constitutionally recognized right to healthcare. This is the result of a landmark decision of the Supreme Court in the 1976 case of Estelle vs. Gamble, which ruled that the lack of provision of medical care was tantamount to cruel and unusual punishment, which is banned by the eighth amendment of the constitution. As a result, county, state, and federal governments are compelled to provide care for their incarcerated individuals, both before and after sentencing. Over the past few years, as a result of the increase in prison populations, the ever rising cost of this provision of care has become much publicized, which drove the issue of treatment of inmates to the forefront. It is estimated that jails and prisons as a group spend

Example 1

A female inmate has a suicide attempt. During the psychiatric interview that follows, she describes having sexual relationships with a correction officer on an ongoing basis and explains that the suicide attempt was triggered by his terminating the affair.

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Example 2

An inmate with a history of polysubstance dependence requests benzodiazepines for "overwhelming anxiety." When the psychiatrist denies this request and suggests a course of action that involves the use of an SSRI together with AA meetings, the inmate brings a formal complaint to the licensing board indicating that the psychiatrist is "providing substandard treatment." The complaint is investigated extensively and found meritless after the medical chart is reviewed.

approximately $1.8 billion a year in the provision of mental healthcare to their inmates. That amount does not include room and board, custody-related expenses, or the high cost of litigation.

THE MENTALLY ILL IN PRISON

Inmates with mental illnesses are often referred to mental health professionals by custody staff. In general, these inmates tend to have difficulties understanding and following rules and regulations. As a result, they tend to commit more violations, spend more time in segregated housing units (those that house inmates with behavioral difficulties), and are less likely to be granted early releases, such as parole or probation. After the referral is made, inmates are typically seen by social workers or mental health nurses who, in turn, refer them to the psychiatrist.

Psychiatrists practicing in this setting face a multitude of unique factors affecting the delivery of care. Correction officers form the basis of every facility. They are in charge of the safety and security of the institution and have the authority to maintain them by enforcing rules. While the relationship with the custody staff is usually cordial and collaborative, officers without a clear understanding of mental illness may become harsh and unsympathetic toward patients, viewing the attitude of mental health staff as lenient and inexperienced. In such cases, the provision of services can be complicated by such dualistic views, and it may take time for a new psychiatrist to form effective working relationships with custody staff, which usually occurs as they witness the results of effective mental health treatment. Some systems, such as the Federal Bureau of Prisons, avoid this approach by incorporating correction officers into the treatment team, which results in cross-disciplinary consultation, assistance in security decisions, and improved staff morale.

Even basic tenets of the doctor-patient relationship, such as confidentiality, are changed by the correctional environment. Correction officers call inmates to their psychiatric appointments, monitor them during medication rounds, and are at times present while nurses dispense treatment. Psychiatrists face a double role as patient advocate while, at the same time, having to participate in the safety and security of the institution (Example 1).

In community settings, the psychiatrist has a duty toward the patient, but usually does not have to intervene in the ongoing (or past) relationship. In correctional settings, a psychiatrist has an obligation to report inappropriate contact (such as in Example 1) even if the patient/inmate asks that such details are not revealed. Similarly, psychiatrists may be compelled to breach confidentiality whenever an inmate describes the possibility of an escape or other security threats.

Working in correctional settings can also expose a prescriber to an increased risk of legal actions, such as medical malpractice claims and complaints to license boards or local or national medical societies, as inmates can be overly litigious. The psychiatrist can then be in the difficult situation of treating someone who has made a complaint against him or her but who cannot freely choose another provider, as would occur in community settings. This highlights the importance of good practices and adequate documentation as a way to minimize the possibility of adverse outcomes (Example 2).

Another common problem in correctional settings is the presence of inmates that engage in disruptive and/or self-injurious behavior, such as flooding cells,

Example 3

A young male inmate sentenced to 10 years for sexual assault is taken to a nearby hospital after introducing a sharp foreign object in his urethra. He has done this five times in the past four weeks, and the staff has assessed this conduct as "manipulating… inmate enjoys the ride to the hospital." In spite of adequate staffing at the correctional facility, the inmate was not readily evaluated by mental health staff during any of the prior incidents. At the hospital, a social worker interviews him and elicits an elaborate delusional system that involves the incident as a way to "atone for his sin."

destroying property, smearing bodily fluids on things, cutting themselves, or swallowing objects. These inmates tend to be identified as "behavioral problems," since most of those disorderly actions often occur in special housing units to which inmates are moved after demonstrating such conduct. Psychiatrists are often called to assess these individuals and to make recommendations regarding placement, transfers to more appropriate facilities, possible interventions, and course of treatment if necessary. While some psychiatric disorders can present with these type of disruptive behavior some of the conditions associated with incarceration may also produce them. For example, isolation, stress, and the need for increased levels of attention can give rise to these types of conducts. Many of these individuals are then rapidly called *manipulators* or *malingerers* by correctional staff. The use of these terms usually correlates with suboptimal mental health evaluations, which can then result in inadequate responses or courses of action to address these behaviors (Example 3).

Example 4

A 26-year-old white man arrested for allegations of sexual molestation of his four-year-old stepdaughter attempts to grab a detective's gun during interrogation in lockup as a way to kill himself. When brought to jail he is placed under constant observation for two days after reporting being overwhelmed with guilt. The observation is discontinued after he commits to safety during a short psychiatric evaluation and is placed in a general population area of the facility. He is found hanging a day later, after tying a piece of cloth from his sheets to the top bunk of his cell.

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Finally, the issue of suicide in correctional facilities is one of enormous importance. The rate of suicide in jails is estimated to be five times that observed in the general population. Suicides are more likely to occur in the first 24 hours after incarceration and victims are typically young men arrested for nonviolent offenses who are intoxicated. The typical method of suicide is by hanging. In prisons, suicide ranks as the third leading cause of death after natural causes and AIDS. The majority are inmates in the early stages of their sentences, convicted of personal offenses, with a history of prior suicide attempts or mental illness. Typical triggers are new legal involvements, relationship issues, or inmate conflicts (Example 4).

Correctional psychiatry is a challenging subspecialty that has evolved from the need to provide treatment to the large number of offenders with mental illness that are behind bars. Professionals working in jails and prisons must fully understand the unique nature of this environment and the population treated. Once they overcome the daunting nature of these institutions, many psychiatrists find this line of work extraordinarily stimulating and gratifying. ●

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