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Prison Psychiatry and Professional Responsibility

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ABSTRACT: Professional responsibility is a multifaceted concept embracing elements of technical competence and accountability. It may seem anachronistic to examine professional responsibility in the context of prison psychiatry, which is a relatively unpopular and often controversial health service activity. Upon closer scrutiny, however, it appears that prison psychiatry presents a paradigm of the uncertainties, conflicts, and dilemmas which underlie current concerns about professional responsibility in psychiatry. In this paper, the author examines some of these issues and proposes some tentative answers, focusing on the critical question of the proper roles of psychiatry in prisons.

KEYWORDS: psychiatry, prisons, professional responsibility

Professional responsibility is a multifaceted concept embracing elements of technical competence and accountability. Traditionally, the practice of medicine has been guided by compassionate and humanistic concerns. Leadership functions of physicians have included the organization of health services, the administration of health care, and advocacy for adequate health care [*1-4*].

The ideals and goals which shape our views of professional responsibility are subject to changes based on social, economic, and political factors [*5-9*]. Differences in local and regional values and traditions also influence our concepts of professional responsibilities. Such differences may be observed in the prison.

Today, the medical profession is faced with demands that it reexamine its concepts of professional responsibility to insure that they are worthy of public trust [*10,11*]. Meanwhile, prison psychiatry has been beset with its own special problem, namely, that of delineating its proper role [*12*].

In my opinion, prison psychiatrists should function as physicians, whose task it is to diagnose and heal illness and to ease human suffering. Toward that end, prison psychiatrists should be responsible for the development and implementation of programs to identify and treat those prisoners who are most obviously mentally ill [*13*].

It may seem anachronistic to examine professional responsibility in the context of prison psychiatry, which is a relatively unpopular and often controversial health service activity. Upon closer scrutiny, however, it appears that prison psychiatry presents a paradigm of the uncertainties, conflicts, and dilemmas which underlie current concerns about professional responsibility in psychiatry. Indeed, the need to maintain professional responsibility in psychiatry is an important factor in the challenge to find hope in prisons.

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Prison Administrators Search for Professional Identity

As physicians debate the limits of their professional responsibility, prison administrators have been trying to establish their own professional identity [*14–16*]. Former goals of treatment and rehabilitation have been repudiated as major purposes of prisons and it no longer seems appropriate to refer to prisons as "correctional institutions." The medical model with its individual treatment plans has been rather emphatically rejected. Thus, today's prison administrators are likely to identify themselves as professional managers, whose primary concerns are security, custody, and overcrowding.

One significant consequence of the shift in emphasis from rehabilitation to management has been a weakening of the prospects for rapprochement between psychiatry and prisons. Thus, while psychiatry was able to share rehabilitative goals with prisons when these were in vogue, psychiatry now has less to share with prisons in the new focus on management strategies, psychiatrists ordinarily being relatively uninvolved in management operations.

Psychiatry and the Medical Model

Psychiatry has also had its problems with the medical model. Basically, conflicts have arisen in our efforts to reconcile theoretical medical models with announced roles and goals [*17–19*]. Let us examine some of the functions and roles which have been recommended for prison psychiatrists [*20–25*]. Perhaps foremost among these are the following: (1) selection and training of prison staff; (2) evaluation of inmates for classification, institutional placement, discipline, parole, etc.; (3) prison reform; (4) treatment of criminality; (5) prevention of illness and dangerousness; (6) treatment of the mentally ill; (7) support to primary care programs; and (8) research.

In considering some of these possible roles for prison psychiatrists, it is important to recognize that psychiatry does not have first claim to many of these functions in prisons. For instance, psychologists have demonstrated proficency in the selection and training of prison staff, and in the evaluation of prison inmates for purposes of classification, institutional placement, discipline, and parole [*26–28*]. For practical purposes, it appears that these activities can be delegated to psychologists, and deleted from the list of possible functions for prison psychiatrists.

Prison Reform

Psychiatry has made significant contributions to prison reform. In the 18th century, Philippe Pinel advocated separation of the mentally ill from the thieves [*29*]. Benjamin Rush, the father of American psychiatry, led the movement to develop America's first penitentiary, which stands as a model for the contemporary prison [*30*]. More recently, psychoanalytic theory has added new dimensions to our understandings of criminal behavior, punishment, and deterrence [*31*]. Harry Stack Sullivan's interpersonal relationship theories, with their focus on communication and feedback processes in interpersonal behavior [*32*], have been widely applied in prison treatment programs, often without recognition of their source.

Psychiatrists who criticize prisons from afar in the name of reform should recognize the likelihood that their critical messages will only antagonize the prison administrators whom they hope to influence [*33*]. On the other hand, psychiatrists who are willing to come into the prisons and assume responsibility for the care of their mentally ill can influence constructive change and reform by advocating for the facilities, resources, and conditions which are necessary for effective treatment.

Treatment of Criminality

Psychiatric approaches to the treatment of criminality appear to be rooted in social theory and traditional medical morality. While one may assume that the intention of these approaches has been benevolent and humanitarian, the results have been anything but that. Thus, for practical purposes, persons whose deviance is attributed to mental illness face essentially the same rejection, isolation, and punishment as those whose deviance is attributed to characterological "badness." Furthermore, the current preoccupation with the association between mental illness and dangerousness can lead to even harsher treatment of the mentally ill deviant [*34*]. In these terms, it seems clear that little is to be gained by equating criminality with illness or defect, be it mental or biological. Psychiatry should be guided accordingly.

Prevention of Illness and Dangerousness

As popular as the idea of the prevention of mental illness may be, a showing of tangible results of preventive efforts remains elusive. The primary prevention of most functional mental disorder has faltered for want of more precise knowledge of etiological variables, if not for want of resources to alter those causes of functional mental illness which have been hypothesized.

Secondary and tertiary preventive efforts directed at early diagnosis and rehabilitation to arrest and prevent the further development of disability are thought to be best accomplished in the context of multidisciplinary treatment programs, such as those which were envisioned in community mental health centers. However, we are now finding that these programs have not been working well because of lack of clarity in the definition of roles for various treatment team members and because of unclear boundaries and priorities [*35*]. In my opinion, this egalitarian role-blurring does not work any better in prison mental health services. I believe that the remedy is to assign the leadership responsibility to qualified psychiatrist administrators, as was once the custom. One hopes that they will once again accept the challenge [*36,37*].

Treatment of the Mentally Ill Prisoner

Contrary to popular opinion, the problem of mental illness in prisons is not one of prisoners who become ill during imprisonment, perhaps as a result of confinement. Instead, it is a problem of mentally ill persons who are entered into the prison system. Thus, the target population for mental health services in the prisons should be the same as that in the community at large, namely individuals whose mental illness results in significant functional disability. Within this framework, the mental disorders that should be given the highest priorities in prison treatment programs are chronic schizophrenia, major depression, organic brain disease, including that which is caused by drug or alcohol abuse or both, disabling neuroses, mental retardation, and various combinations of the foregoing. Prison psychiatrists should make no pretense of treating character and personality disorders, adjustment problems, reactive depression, and the so-called "problems of living" [*38*].

Some of the most critical conflicts for prison psychiatrists arise in the course of their efforts to treat mentally ill offenders. A typical dilemma occurs when the psychiatrist has to weigh the interests of his prisoner patient against those of the free community when prognostic questions arise [*39*]. Among the critical issues are treatability, readiness for reductions in custody, and ultimately, suitability for release.

In my opinion, it would be much better if psychiatrists would reassert their traditional primary loyalities to their patients, define their patient care and advocacy roles, and most importantly, decline primary responsibility for administrative decision-making concerning such matters as custody, discipline, institutional placement, and release.

Prevalence of Mental Disorder in Prisons

The prevalence of mental disorder among prisoners has never been accurately known because screening programs to identify mentally ill prisoners are usually inadequate [*40*]. Meanwhile, social and demographic factors are putting more mentally ill persons at risk of arrest and imprisonment. The incorporation of newly evolving concepts of relationships between mental disorder and dangerousness into sentencing practices is causing more mentally ill offenders to be sentenced to longer terms of imprisonment. Diminished access to mental hospitals is causing more mentally ill persons to be jailed. Mentally ill offenders are no longer being diverted to hospitals, while there is evidence that the diversion of mentally ill persons from jails to prisons is occurring with increasing frequency [*41-44*].

Research

It is difficult to put research in perspective in prisons. The needs are so great, the resources are so small, and the hopes are so fervent. The use of prisoners as subjects for experiments has been controversial [*45*].

In charting the research needs for prison mental health services, I would give first priority to the establishment of epidemiological research units. Such units should be responsible for the evaluation of program activities, service utilization patterns, the demography of service users, and assessments of the prevalence of various disorders in the populations served [*46*].

Trends in Clinical Psychiatry

Recently there has been concern that psychiatrists are moving away from direct patient care and away from the mainstream of medicine [*47-49*]. Prison psychiatrists have unique opportunities to care for patients with all manner of ills. For instance, they can attend in the primary health care clinics, where many prisoners with diagnosible mental disorders are seen. Psychiatrists working with general practitioners, internists, and other medical specialists in prison primary care clinics may develop new models for interspeciality collaboration. Psychiatry can get closer to the mainstream of medicine by becoming involved in primary care programs in the prisons [*50*].

Problems for Prisoner Patients

It is probably fair to state that no one, prisoners included, wishes to be mentally ill. Clearly, there is little advantage to being mentally ill in prison. Prevailing suspicions that mentally ill prisoners may be feigning or exaggerating always work to the prisoner's disadvantage. The current inclination to associate mental illness with dangerousness also works to the disadvantage of the mentally ill prisoner when he is under consideration for institutional placement, for access to institutional opportunities, and perhaps most importantly, for release. Under these circumstances, prisoners have little reason to feign mental illness. On the contrary, I believe that they are more likely to feign sanity, and to deny illness, to overcome the manifest disadvantages of being mentally ill in prison.

Prisoners who deny illness are generally resistent to treatment. Conventional wisdom tells them that they are in prison for punishment, and they are often mistrustful of treatment offers. Prisoner patients who have little choice in selecting their therapists must be persuaded that their therapists really care about them. The authoritarian and coercive pressures present in most prisons are hardly conducive to the development of therapeutic alliances premised upon compassionate caring.

The Antipsychiatry Movement

Prison psychiatrists are peculiarly susceptible to criticism from the antipsychiatry movement, whose major concern appears to be that psychiatrists and psychiatric institutions can do harm to patients [*51*]. Fears that prison psychiatrists may misdiagnose prisoners as mentally ill to discredit them, or that they might employ coercive treatments to control prisoners, are fairly prevalent. It is unfortunate that some of our prestigious colleagues have lent some credence to these misconceptions of psychiatry through their sometimes contentious writings [*52*]. Eventually, one hopes that the psychiatric profession will present a more unified front in which it repudiates the destructive efforts of those who seem so determined to discredit psychiatry. Certainly, prison psychiatrists will be able to operate more comfortably behind such a front.

Rights Issues

In some ways it seems paradoxical that the pursuit of basic civil rights for the general population has led to diminished access to care for large groups of mentally ill persons, and at the same time left institutional psychiatrists to defend their participation in programs with known deficiencies. Perhaps, predictably, the most critical debates over treatment rights have occurred in institutions which have the most deprived treatment programs and treatment resources [*53–55*].

Deciding the treatment rights of patients residing in the most impoverished of all treatment settings has posed some difficult questions. In the prisons, where drugs are the mainstay of psychiatric treatment, the debate has focused on the efficacy of drugs, the potential for harm from drugs, and indications for the forcible use of drugs [*56*]. This focus tends to narrow care options and diminishes patient participation in care plans [*57*].

Presumptions of the institution's right to force medications to prevent dangerousness and to preserve institutional safety and discipline tend to preempt the patient's right to refuse medications and further delimit the scope and quality of treatment. It should be apparent that this model for the use of psychotropic drugs intensifies adversarial elements in the physician/patient relationship, and can only be detrimental to care programs. It seems to me that the ultimate answer to this dilemma is to involve more skilled and sensitive clinicians in the care of these deprived populations to raise the level of professional competence and responsibility in the delivery of these health services. The numbers of confrontations which lead to court intervention could be reduced by employing more skilled clinicians who are sensitive to their patients' concerns and needs, and who are flexible and in a mood to negotiate with their patients [*58*].

Politics

It is important to recognize that the interests and expectations of the community follow the offender into the prisons. The extent to which these kinds of considerations impact on the treatment of mentally ill prisoners varies with the case, the prison system, and the time. Thus prison psychiatrists may be subjected to political pressures. Most physicians will be impatient with political interference; some will withdraw, while others may seek to become political activists in their own right. I suggest a middle ground which I believe to be closer to the physician's traditional role. In this role, I would hope that the physician would strive to preserve his own dignity and that of his patient, acting as a moral persuader in the advocacy of his patient's best interests [*59*]. This should reinforce hope and trust, both essential ingredients of the physician/patient relationship and without which there can be no treatment at all.

Standards

Experience suggests that demand for prison reform and the establishment of standards have flowed largely from the serendipitous exposure of significant deficiencies, as in the aftermath of prison disturbances or in the course of prisoner initiated litigation. I suppose we should be hopeful that the promulgation of standards will stimulate interest in prison health services [*60-63*]. However, we must recognize that standards in themselves will not remedy present-day deficiencies in prison health care programs. In fact, standards can diminish initiative and responsibility and encourage the adoption of defensive and adversarial postures [*64*].

We should also hope that prison administrators will recognize the plight of mentally ill prisoners and seek the help of physicians in dealing with this health care problem. This will require the participation of psychiatrists who possess broad experience and consummate clinical skill. In this vein, let me share with you a statement of the responsibilities of the prison physician, which was proposed in a mid-19th century North Carolina state legislative report. It reads as follows:

> He shall make strict examination into the mental condition of every prisoner, and if he finds that the discipline or confinement of the prison or any other appreciable cause accounts for any prejudical influence on the mind that he may discover, he shall order such change as he shall deem best [*65*].

Conclusions

The reform of prison health care programs remains in its infancy, and the reform of prison mental health services awaits conception. Efforts to improve prison health care will require stronger physician support. The task is one for all clinicians, not just those of "forensic" persuasion [*66*]. Further debate over where the care should take place is moot; the mentally ill are in the prisons [*67*]. The highest levels of clinical skills and accountability are required to ensure that care is not suborned to the punitive purposes of prisons. It is time for physicians to make the pilgrimage to the prisons as an act of faith, hope, and commitment to our ultimate professional purposes.

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