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A Glimpse into the Forensic Psychiatrist's Surgery in the "De IJssel" Penitentiary

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ABSTRACT – The author focuses on the work of the prison psychiatrist in particular. Problems like his findings in respect of detainee care, specially in the case of illegal detainees, illegal immigrants etc. Could it be that the forensic psychiatrist, by virtue of his trash-can function, is also reflection of some of society's own errors and failings? We can read some of these problems in this article.

Introduction

The "De IJssel" Penitentiary in Krimpen a/d IJssel, the Netherlands, comprises a Remand Centre (180 places), and a prison (180 places).

The medical care of detainees in the "De IJssel", is placed in the hands of behaviour specialists, such as the prison doctor, the prison psychologist and the judicial forensic psychiatrist (jfp), formerly known as the 'district psychiatrist', henceforth: psychiatrist). The psycho-medical consultation (PMC)[1] is the coordinating advisory body responsible for medical care within the penitentiary. It operates as a kind of 'sounding board' for the management team, and as a 'tuning-in' point for individual carers. The PMC usually comprises the psychologist as chairman, the prison doctor, the psychiatrist, and invariably a probation worker as well. The nurse attached to the prison medical service and sometimes (although not in "De IJssel") a member of the social service bureau (SSB) will also take part in

1. See also P.E.M. Leenaars and A.M.J. de Kuiper, Psycho-medische zarg en het psycho-medisch overleg (= Psychomedical care and the psycho-medical consultation body) In: Psychiatrie en Justitiabelen (Psychiatry and Justiciables) (Ed. T.I. Oei and A.M. van Kalmthout), Gouda Quint, Deventer, 1997, pp. 153-164.

PMC meetings, bearing in mind that such professionals can often give important, relevant and up-todate information on individual detainees.

It is important that the PMC meets on a weekly basis and that its decisions are recorded so that the prison management team can, when required, have access to the most essential information in order to corroborate and support detainee carepolicy.

It is also important to know which data specific to individual detainees contribute, or do not contribute, to the detainee's mental and/or physical problems, and how such problems can be solved in the detention situation in a way that is sociallymedically and judicially acceptable. The prime concern is that the detainee's medical and psychological condition must not be allowed to deteriorate: hence the acceptance of medical care and treatment services within the institution.

The psychiatrist fulfills a double role, in fact. On the one hand, he informs and advises the judge, and on the other hand he must not lose sight of the detainee's individual care needs. When both roles have to be fulfilled at one and the same time, the psychiatrist must immediately relinquish his informant role on the detaince's behalf, in the interests of serving his (the detainee's) specific care nseds. By the same token, when the psychiatrist acts as informant for the judge, he cannot then be implicitly involved in the detainee's care needs - he is thus free to fulfil his independent and unbiased role as the judge's informant and advisor. It is possible for the psychiatrist, as carer, to advise the judge and draw his attention to a detainee's possible psychopathological or disturbed behaviour, so that as the occasion arises –such as the absence of a behaviour specialist's report– a pro Justitia letter or written report can be presented instead (with the consent of the detainee in question).

The present paper focuses on the work of the prison psychiatrist in particular. What, for instance, are his findings in respect of detainee care? What are the problems he meets, and what specifically is this paper intended to spoLlight? In terms of the latter, it is the responsibility placed on the psychiatrist[2] to provide the necessary care for illegal detainees, which lies at the forefront of his work. Which behavioural-specialist considerations underlie this finding? In other words, could it be that the forensic psychiatrist, by virtue of his 'trash-can' function, is also a reflection of some of society's own errors and failings?

Study method during the period October 1996-October 1998 (henceforth: 96/98)

The "De IJssel" opened its gates in May 1996, and the first detainees arrived. Detainee- care lay in the hands of the psychiatrist, from the start[3]. The method followed was

2. P. C. Vegter regards treatment by a physician and behaviour specialist within the prison system as a realistic possibility, as also from the juridical point of view (and then subsidiary to the prisoners period of detention). See P.C. Vegter. BebandeJen in de gevangenis (= Medical treatment in the prison): Inaugural Lecture. Catholic University. Nijmegen (NL). Gouda Quint. Deventer. 1999.

3. In the period May-September 1996, the information then registered was sean as the 'practice-and-training phase' of the present study. This research should be regarded as no more and no less than a pilot study, and thus merely as a signal.

that the psychiatrist recordad each consultation, in which he himself examined the detainee, both in his own files, and in the so-called Microhis PC-archive, a well-known medical registration system. Other consultations –such as the probation officer or another social worker/behaviour expert wanting to talk about a particular detainee– were usually discussad and minuted during PMC meetings.

The name, age, detention number, and the matter about which the consultation was requested, were duly noted. In most cases, the psychiatrist made his preliminary diagnosis at this point. The data was then fed into the FRIS system, a registration system which has now reached its second phase in the FRIS II system. Any information arising from the FRIS is not discussed at this point, in the knowledge that it will be discussed and processad in another context at some other time.

The psychiatrist attended the prison for four hours twice a week. During those hours, he attended PMC meetings; individual consultations concerning specific detainees were also held with the prison doctor, the psychologists, the nursing staff, as well as representatives of the prison chaplaincy and the probation service. A meeting with the prison management team and the psychologists, was held every three months. There was also intensive contact with detainees being held in the observation cell - they were also visited on a daily basis by the psychologist and prison doctor. The psychiatrist visited such detainees whenever he was on the premises. The prison doctor consulted him during and outeide office hours, whenever necessary. When referral to other services was required, such as to the Forensic Observation and Supervision Department (FOSD) in Amsterdam, contact was sought by telephone, followed immediately, usually by fax, by the letter of introduction. This letter was addressed to the FOSD psychiatrist, with a copy to both the Judicial Health Bureau (headed then by J. Eizenga, psychiatrist, and later by Prof. Dr. H.J.C. van Marle), and the Justice Departmentis Individual Decisions Service (headed by F.M. Kerkhof).

Results

On average, the psychiatrist received five consultation requests from detainees during the course of each of his 4 hour sessions at the prison. The nursing staff then arranged the necessary appointment for the detainee to attend the psychiatrist's surgery. The consultation request was, in most cases (651) initiated by the prison doctor, in another 20% of the cases primarily by the PMC, whether or not in consultation with the prison's own detention council, and another 15% by the prison psychologist. Only in a very few cases did requests for psychiatric expertise consultations for individual detainees, originate directly from the prison management offices. The consultations thus archived by the psychiatrist concern more than half (65%) of the total number of consultations/contacts which took place with, or about, individual detainees.

The ensuing figures differ according to the extent and sequence of the method actually applied by the psychiatrist. If, for instance, feedback is given during the course of a PMC moeting or to its psychologist chairman, about the psychiatrist's contacts immediately after the consultation, then the number of psychiatric consultations requested directly by the PMC will inevitably be fairly limited. It is always the psychiatrist, or the prison doctor, who then takes the lead

in arranging the consultation. If a psychiatric consultation is only arranged when the PMC explicitly requests it, then the relative percentages between the consultation requests will, of course, be different. From a medical and health-law point of view, the sequence we followed is probably to be preferred: firstly, contact with the prison doctor or prison psychologist, and then the psychiatrist, was followed by feedback to the PMC and others. The physician is then able to decide for himself just how much medically relevant information he will pass on to non-treaters in the PMC; in other words: which information, belonging to the professional-secrecy, privacy-sensitive, area of his work must, and may, he surrender to others? Once again, medical care must, in the final analysis, ensure that there is no decline in the detainee's general state of health. Treatment, as such, does not take place in the prison itself (i.e. the psychiatrist's consulting room is neutral ground). There is thus no pressing reason for detailed and personally relevant information about a specific detainee, to be given to the PMC or other non-treaters.

During the period 1997-1998, the psychiatrist was consulted by detainees on 525 occasions. This number included repeat consultations with particular detainees within a certain detention period, in more than 25% of the cases. Repeat consultations were usually initiated by the prison doctor, the prison psychologist, the PMC or the psychiatrist himself. In matters concerning individual care, it was the PMC which increasingly became the central platform from which to advise the management. Judicially complicated issues - for instance, the question of whether a high-escape-risk detainee should be left alone with his wife, without a prison officer (PO) being present, for the purpose of their fulfilling a long-held wish to have a child - are first of all, as in all matters relating to detainee-care, submitted by the prison management department to the PMC for its advice.

As a result of this, cooperation between the PMC and prison management became standard procedure during the course of 1997 and 1998. The psychiatrist can also contribute to this, thanks to his independent position as consultant. The management also soes from its side, that this kind of joint cooperation, between forensic psychiatric consultant, the PMC, and the prison itself, can only lead to a qualitively effective working climate for all. Independencies are thus kept to a minimum, bearing in mind that each person's responsibility ensures that picking-up any signs of omissions and short-falls in respect of detainee-care and reporting, becomes a very relevant undertaking - for the psychiatrist especially.

What diagnoses are we concerned with here?

The psychiatrist's diagnoses are based on the actual clinical signs and symptoms, tested against the DSM-IV criteria[4], and discussed with the PMC. There was no question of a standardised diagnostic interview. In doubtful cases, however, impressions gathered by colleague forensic psychiatrists and psychologists, were included in the diagnostic evaluation, i.e. through means of a 'second opinion', such as in the case of

4. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Washington DC: APA.

uncertainty about the presence, or otherwise, of a borderline personality disorder or lack of concentration disorder coupled with hyperactivity/ADHD. In more than 50% of the cases, the diagnoses were usually regarded as so obvious that further testing, apart from the DSM-IV criteria crosscheck, was not thought to be necessary.

The diagnoses were then clustered, whereby the personality disorders, in particular, fell into three groups: borderline, anti-social, and narcistic personality disorder. The independent personality disorders we encountered, fell into the drug abuse cluster category. The psychiatric diagnoses were grouped into large affective disorder clusters (including anxiety disorders with, or without, a psychotic component), post-traumatic stress disorder/PTSS, ADHD, of which the last three affected only three detainees, drug abuse (with, or without, psychotic symptoms), the organic (epilepsy/debilit) disorders, and psychotic images of the mentally retarded, as well as a schizophrenia group, which included both schizoaffective disorders and schizophrenic psychoses. In the event of there being no question of minor psychopathology, those examined were included in a separate category.

The number of consultations (total, including repeated consultations: 633) divided into diagnosis clusters, as follows

Narcistic personality disorder (npd): 7
Borderline personality disorder (bpd): 41
Anti-social personality disorder (apd): 78
Drug abuse (da): 149
Schizophrenic psychoses p): 193
Affective disorders (ad): 1 8
No psychiatry (np): 34
Psycho-organic disorders (pod): 13

In roughly 20% of the consultations, there was some evidence of comorbidity, such as mental retardation and drug abuse.

It should be borne in mind that the main focus of this study is the psychiatrist's own surgery pattern, i.e. the number of consultations given (and reported on to the prison doctor) by the psychiatrist to detainees with a particular psychiatric disorder. The number of consultations was determined for 25% by the severity of the pathology, whereby repeat consultations were required, agreed on between the psychiatrist and the detainee. In addition, roughly 10% of these consultations took place as a result of prison doctor or prison psychologist referral. If, for instance, the doctor, was repeatedly asked by an addicted detainee to prescribe benzodiazepine or methadone, then the doctor would first of all refer him to the psychiatrist asking if there was evidence of any kind of psychiatric disorder, such as psychosis or depression. If this was not the case, the doctor could then prescribe medication accordingly - on the assumption that there would be no deterioration in the detainee's general physical and psychic condition. In practice, it followed that the detainees request was refused, or that the detainee was, if possible, given a non-benzodiazepine-type sleeping tablet - on the basis of limited quantity and limited duration. Indeed, it is not unusual to see former drug-abusers leaving the penitentiary completely freed of their drug or benzodiazepine addiction[5].

5. A number of them state their desire not to use drugs again, a fact which in a few cases was confirmed a year later, namely that they were no longer drug-dependent.

In such cases, the medical policy within the penitentiary worked not so much as a means of preventing both physical and mental deterioration, but rather as a cure in purely medical terms.

It has to be said, however, that in cases of serious drugdependence (often after many years of methadone use, and usually in combination with benzodiazepines) there is sometimes a medical contra-indication to stopping the use of methadone.

How many illegal aliens are involved here?[6]

In 150 cases (25% of the psychiatrist's consultations), the consultations concerned people who had made their way illegally into the country. Another 20% of the total, cover repeat-consultations during one and the same detention period.

The division over the various diagnostic clusters was as follows: Anti-social personality disorder 10; drug abuse 26, schizophrenic psychoses 70; affective disorders 17; no psychiatry 7.

It should be said at this point that the question of legal or illegal residence in the country, played no significant role in the consultations. It was mostly a question of detainees on suspicion of having committed an offence being held in custody pending police investigation, and feeling unable to (sufficiently) control `their nerves`; therefore, they sought the help of the medical service and the psychiatrist.

Considerations

Although it is only possible to give global impressions in a pilot study of this kind, there is one aspect in particular that stands out, and it is one that may be of significance in terms of behavioural policy generally. The large number of psychiatric consultations with and about detainees, be they legal or illegal, is striking.

And particularly interesting in this remains the occurrence of a considerable degree of schizophrenia or schizophrenic-type pathology[7], i.e. similar to schizophrenic psychoses, also (or perhaps precisely) occurring among a prisonis illegal immigrant population. In this context, it would be safe to assume that many of them, as other studies among psychotics have already shown, having been unable to obtain direct help in a psychiatric hospital, have found themselves down and out, and driven into criminality - whether or not the cause lies in chronic soft or hard drug abuse; in such cases, the judicial circuit was usually the end of the road for them. Psychotics are usually returned to the streets quite quickly, in response to society's current view that human autonomy is paramount; if at all possible, everyone should be able to live his/her life according to his/her own tastes, viewpoints and ideas. The psychotic, however, is

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6. With thanks to A.M.J. de Kuiper, psychologist/neuro-psychologist in "De IJssel", for his help in gathering the data. I am also to the nurses attached to the prison medical service for their valuable assistance.

7. It may happen practice that flash-backs described by traumatised detainces, are regarded as hallucinations whereby a post-traumatic stress disorder diagnosis is incorrectly missed. Compare Th.R. de Graaf, Trauma and Psychiatry, Doctoral Thesis, Tilburg University of Brabant, Tilburg University Press, 1998.

not in need of an autonomous existence as such, but rather a structure and a life with and among others who understand him, and try to help him (learn to) bear his suffering. It goes without saying that an illegal immigrant needs the specific help and support of others, including government agencies.

That the 'Koppelingswet' (a new Dutch law governing illegal immigrants), for instance, plays a demotivating role in the question of whether an illegal psychotic can expect the necessary psychic help from Ministry of Health agencies, constitutes a social problem in itself. Hospitals often have to work through long waiting lists, and will undoubtedly take due account of the illegal status of someone in need of psychiatric care, when deciding if such a patient should be admitted for treatment - or in the case of a 'legal' psychotic, take steps to find a suitable solution. It cannot be said with any certainty whether or not the latter situation occurs to any satisfactory degree. It has become clear, however, that agencies endeavour, first of all, to find all kinds of funding sources which will cover the not inconsiderable hospital admission costs involved in such cases. This is, at the very least, a time-consuming exercise, which in turn means a considerable delay in -comparison with admission-policy for legal, and insured, residents[8].

It is not clear what is meant by "medically necessary" in the 'Koppelingswet'. The Medical Essential Care Working Group recently (January 1999) presented its definition: help is medically necessary "When a detainee finds himself in a (threatening) precarious situation, in which his, or someone else's, physical or mental health is at stake. "In practical terms, the Working Group states that a medical need arises"... when there is an urgent care-need, deriving from a psychiatric disorder, and that treatment in a Mental Health Care Institution is indicated". The Group is trying to balance on two concepts. The suggestion is made, implicitly and explicitly, that there are psychiatric conditions which require no treatment within the Psychiatric Care (PC) system. I wonder, in that case, which disorders are implied here. I notice in practice, for instance, that impulsive disorders, such as ADHD and severe borderline personality disorders with psychotic manifestations, are unpopular within the Mental Health Care system. There is primarily a considerable lack of treatment facilities for these groups[9]. These patients also often remain untreated in a back room somewhere and lead in consequence - damaged too perhaps by long-term drug abuse - a completely inadequate and vagrant existence, in view of the fact that psychiatric professionals are unable to find an anewer to their problem. This is sometimes aided and abetted by restrictions which institutions feel impelled to impose on their staffs because of limited budgets. I would have thought that Mental Health Care

8. See P.J.A. van Panhuis's Doctoral Thesis: De psychotische patiént in de TBS (= The psychotic court order patient), Gouda Quint, Deventer, 1997; and compare further with B.H. Bulten, Gevangen tussen straf en zarg (= Imprisoned between punishment and care), Doctoral Thesis, Free University, Amsterdam, 1998, C. Schoemaker and G. van Zessen, Psychische stoornissen bij gadetineerden (= Psychic disorders among prison detainees), Trimbos Institute, Utrecht, 1997.

9. Compare further: T.I. Oei, De gerequleerde toekamst van tés. Problemen en oplossingen (= The regulated future of court orders. Problems and solutions), DD (Journal of Criminal Law), 30, 4, 2000, pp. 336-3s3. (Ambulant) clinics and clinical psychotherapy departments have, for economic reasons, had their capacities reduced or withdrawn altogether.

treatment - be it ambulant or clinical - is always imperative for psychiatric disorders.

It remains unclear which is the decisive moment at which a medical necessity' indication is called for. The Dutch Health Minister recently expressed the view that it is totally unacceptable that earlier in the year (1999) a Dutch hospital had refused to operate on a illegal female immigrant. According to the minister, the provision of medical help for illegal immigrants should not be limitod to life-threatening situations only. The term "medical necessity" originates from an earlier version of the 'Koppelingswet' implemented in 1998, and which otherwise precludes all illegal immigrants from most of the Dutch social services[10].

In view of the fact, therefore, that doctors are being given more space in which to help illegal and sick immigrants to get the help they need without the sword of Damocles (read 'Koppelingswet') hanging over their heads, how can it be explained that in the penitentiaries generally, the "De IJssel" in any case, so many illegal immigrant detainees show so many psychic and psychiatric disorders? And how can it be explained that every time a new it becomes apparent that our socially and medically 'weaker brothers' are not being helped there where they should be helped: i.e. in the general, or the psychiatric, hospital? If the fact that the penitentiary is there only for those who have violated a social norm is a reflection of the social reality, then the number of psychically disturbed illegal immigrant detainees should actually be but a fraction of what it is today in "De IJssel": i.e. 25% of the total number of psychiatric consultations held there.

It has become apparent that the penitentiary has become a kind of 'refuge' for many illegal immigrants, with or without psychic problems. When they violate criminal law in some way varying, for instance, from threatening behaviour towards a pedestrian, to openly stealing a packet of apple juice from the supermarket, then the threat of detention hangs over them. In normal society, people either behave themselves or they do not - and if they behave badly then prison is the only answer. All they need is a roof over their heads. If that is indeed the prevailing mechanism for dealing with psychically disturbed illegal immigrants, then the penitentiary fulfills not only a judicial function. It also apparently constitutes a place where social justice can be found : i.e. the 'illegal' detainee will at least have access to the same quality of medical care as the 'legal' detainee.

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10. See also de Volkskrant (= national daily newspaper), 14-04-1999, p. 3. Illegal immigrants have limited access to care provisions. The TNO Prevention and Health study 'Access to care provisions for illegal immigrants", carried out on behalf of the Ministry of Health, Welfare and Sport, stated in very clear-cut terms that two years following the implementation of the 'Koppelingswet' access to first and second line care provisions was tight indeed. The study also announced that an estimated 100.000 illegal immigrants in The Netherlands as a result of the 'Koppelingswat', are hardly able to draw on psychiatric hospital after-care service, rehabilitation, and chronic care services. Access to hospital care is also not without its obstacles, although GP care is usually available. According to the researchers, there is a risk, however, that willingness to help illegal immigrants is declining. And in regions devoid of a care-platform, there is uncertainty about how care will be financed. Professional caregivers can, under certain conditions, call on the Stichting Koppeling (= the Koppeling Foundation), which has eleven million guilders per year at its disposal, of which 5 million was used last year. Many professionals appear to be unfamiliar with the necessary procedures, or are reluctant to tackle the administrative 'red tape'. (Curs. TIO). In : Medisch Vandaag (= Medical Today), 11, 7 June 2000, p. 5. It is thus becoming almost impossible for the voiceless illegal immigrant to get proper testing and treatment.

Lady Justice, it would seem, is an honoured sister of the Good Samaritan - no need, however, for pride. The right to proper medical care should, regardless of rank or status, be put into daily practice, both in material and immaterial terms. Or do we tend to bow our heads in acquiescence - come what may - to the dichotomy already evident in today's health care system? A dichotomy which leads society's 'legal' outcasts, and now its 'illegal' outcasts as well, to commit morally unacceptable acts in order to force government agencies to give them the care they need?

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