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CLINICAL PROFILE OF PATIENTS ATTENDING A PRISON PSYCHIATRIC CLINIC

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ABSTRACT

Psychiatric morbidity is higher in prison inmates as compared to that in general population but treatment facilities are often inadequate. The present work reports the profile of psychiatric patients seen in a jail hospital over a period of three months. The jail had about 9000 inmates. Psychiatric services consisted of weekly visit by a psychiatrist. Seventy two male inmates were seen during the period of study. Most of them (80%) were undertrials. Diagnosis included schizophrenia, depression, bipolar disorder, anxiety disorders, and malingering. Stress of imprisonment contributed to the illness only in a small percentage of patients. Among the admitted patients, jail environment interfered with improvement. Frequent relapses were noted among the improved schizophrenic patients when transferred back to the jail. The study emphasises the need for improving the conditions in jail and developing prison psychiatric units to be managed by psychiatrists.

Key words : Prison psychiatry, forensic, crime, clinic, psychiatric services

Psychiatric morbidity is quite high in the prison but treatment facilities are often inadequate (Gunn and Taylor, 1993). Morbidity surveys done in prison population have reported that around 31-37% of inmates suffer from some kind of psychiatric illness (Gunn et al., 1991; Gunn and Taylor, 1993; Fido and al Jabally, 1993). In the British study by Gunn et al.(1991) common psychiatric disorders seen in prisons included personality disorders, substance abuse, and neurotic disorders. Psychotic disorders were the diagnoses in just 2% of the prison population. Fido and al Jabally (1993) in their study from a Kuwaiti prison found 25% of the inmates to be suffering from generalised anxiety disorder of reactive nature. Other common diagnoses included personality disorders, alcoholism and substance abuse. Psychotic disorders were less frequent. However, it is well documented that prevalence of major mental disorders like schizophrenia and major affective disorders is higher in prison population as compared to that in general population (Teplin, 1990; Gottlieb et al., 1987; Hodgins & Cote, 1990).

Facilities for psychiatric treatment are often not adequately developed in the prisons even in the Western countries like U.K. or U.S.A. and are not sufficient to provide services for the enormous psychiatric morbidity in the mentally ill offenders (Teplin, 1990; Gunn et al., 1991). Psychiatric patients in prison often have little exposure to psychiatric treatment in many countries (Fido and al Jabally, 1993).

Situation is not much different in India. Indian prisons also suffer from overcrowding, because number of inmates often far exceeds the sanctioned capacity which further burdens the already scarce medical services. Psychiatric services are nearly non-existent in most of

the Indian prisons. No data regarding psychiatric morbidity in prisons is available from India. The present work reports clinical profile of patients seen in a prison psychiatric unit over a span of 3 months.

MATERIAL AND METHOD

The study was carried out in Central Jail, Tihar, Delhi. The jail has a capacity to keep 2000 inmates, but at any time there are around 9000 inmates staying. Most of them are males. There are only about 300 female prisoners. A large number of prisoners (upto 80%) are undertrials and their criminal cases are still in different stages of the legal process. About 20% of prisoners are convicts and are serving their sentence.

Psychiatric facility consisted of an enclosure of 20 cells in the jail hospital to keep psychiatric patients, in which 30-35 patients were kept. Staff included nurses, attendants, junior residents and medical officers, who covered the whole jail hospital, though one junior resident had an exclusive responsbility to look after the psychiatric patients. The specialist care consisted of a weekly visit by a psychiatrist. The visiting psychiatrist also provided consultation to patients with psychiatric problems referred from other clinics. The assessment consisted of clinical examination. No psychodiagnostics were carried out. In emergency situation, the patient would be sent to the Institute of Human Behaviour and Allied Sciences, Delhi, which also provided the services of visiting psychiatrist.

Sample consisted of patients admitted in the psychiatric inpatient unit of the jail hospital and those referred to the weekly psychiatric clinic from the other general outpatient clinics of the jail. All the patients seen over a period of 3 months (July 1996-September 1996) were included in the study. During the study period, thrice a call was received from the female ward of the jail and 4 patients were seen there. A detailed psychiatric history including socio-demographic and crime related information were recorded. Diagnoses were made as per ICD-10 (WHO, 1992).

RESULTS

Seventy six patients attended the psychiatric facility during the study period. These included 32 new patients and 44 follow up patients. Thirteen (17%) were convicts and 63 (83%) were undertrial prisoners. Most of them were males. There were only 4 female patients and all of them were undertrials. Female patients have been excluded from the analysis so as to keep the sample homogeneous.

Socio-demographic characteristics of the sample are given in table 1. Most (92%) of the

TABLE 1
SOCIO- DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE (N=72)

	Variables	N	%
A	Age (in years)		
	Upto 20	4	5.56
	21-35	45	62.50
	36-50	21	29.17
	Above 50	2	2.78
B	Education		
	Illiterate	16	22.22
	Primary	23	31.94
	Matric	24	33.33
	Graduate	4	5.56
	Postgraduate/Professional	5	6.95
C	Occupation		
	Unskilled	13	18.06
	Skilled/Semiskilled	28	38.89
	Agriculture	8	11.11
	Small business	12	16.67
	Clerical	5	6.94
	Professional/executive	6	8.33

TABLE 2
DURATION OF STAY IN PRISON

Duration	Major crime (N=30)	Minor crime (N=42)	Total (N=72)
Upto 1 month	3.33	42.86	26.36
> 1-6 months	10.00	19.05	15.28
> 6 months-2 years	16.67	9.52	12.50
> 2-5 years	33.33	19.05	25.00
> 5 years	36.67	9.52	20.83

TABLE 3
DURATION OF ILLNESS

Duration	Major crime (%) (N=29)*	Minor crime (%) (N=41)*	Total (%) (N=70)
Upto 1 month	6.66	33.33	22.22
> 1-6 months	20.00	21.42	20.83
> 6 months-2 years	23.33	9.52	15.27
> 2-5 years	26.66	14.28	19.44
> 5 years	20.00	19.04	19.44

*Duration not known for one patient each in both the grops

TABLE 4
DIAGNOSTIC DISTRIBUTION OF THE SAMPLE

Diagnosis	Major crime (%) (N=30)	Minor crime (%) (N=42)	Tota l (%) (N=72)
Schizophrenia	43.33	14.28	26.38
Depression	16.66	19.04	18.05
Bipolar affective disorder	6.66	7.41	6.94
Psychotic disorder NOS	3.33	30.95	19.44
Susbtance abuse disorders	-	16.66	9.72
Anxiety disorders NOS	6.66	-	2.77
Somatoform pain disorder	3.33	-	1.38
Adjustment disorder	3.33	2.38	2.77
Malingering	6.66	-	2.77
Insomnia	-	2.38	5.55
Epilepsy with psychosis	10.00	2.38	5.55
Uncomplicated epilepsy	-	2.38	1.38
No psychiatric problem	-	2.38	1.38

TABLE 5
DIAGNOSTIC DISTRIBUTION AND NATURE OF CRIMES COMMITTED IN MALE PATIENTS HAVING PSYCHIATRIC ILLNESS BEFORE THE COMMITMENT OF CRIME (N=27)

Diagnosis	Number	Type of crime
Bipolar affective disorder	3	Dacoity -1, travelling without ticket-1 socially disruptive behaviour-1.
Depression	5	Theft-2, murder-1, rape-1, attempt to murder -1.
Schizophrenia	7	Murder-4, dowry death-1, theft-1, fight-1.
Opioid dependence	2	Dacoity-1, stabbing-1.
Alcohol dependence	5	Stabbing -2, rape-1, fight-1, drug trafficking-1.
Psychotic disorder NOS	1	Theft.
Dementia	1	Murder.
Epilepsy with psychotic disorder NOS	2	Murder-1, drug traffick-ing-1.
Uncomplicated epilepsy	1	Stabbing

patients were between 21-50 years of age. Only a few were below 20 years or above 50 years. Twenty two percent of the sample was illiterate, 31% were educated upto primary and 33% had completed their matriculation. Twelve percent of the patients had received college education. Most (57%) of the patients belonged to the skilled/unskilled category. Seven percent held clerical jobs and 8% belonged to the professional/executive category.

Forty two percent of the patients had been involved in major crimes like murder, attempt to murder and terrorist activities, whereas the rest had allegations related to minor crimes like theft, robbery, sexual offences (rape, sexual assault and child molestation), drug related crimes (drug trafficking), culpable homicide and non-violent offences. Duration of stay of the patients in prison varied from 3 days-12 years. Forty six percent of the patients had been in prison for a duration of more than 2 years. This included 70% of the patients involved in major crimes and just 29% of those involved in minor crimes. Nearly one-fourth (26%) of the sample had duration of stay less than 1 month. This group included 43% of the patients arrested for minor crimes and just 3% of those involved in major crimes (Table 2).

Duration of illness varied from 2 days to 16 years. One-third of patients arrested for minor crimes were symptomatic for a period of less than 1 month, compared to 7% of those involved in major crimes. Nearly 20% of the patients each in both groups had duration of illness 1 to 6 months or more than 5 years. table 3 gives the detailed distribution of the

sample according to duration of illness.

Diagnostic distribution of the sample is given in table 4. Schizophrenia (26%), unspecified psychotic disorder (19%) and depression (18%) were the three most common diagnoses forming 64% of the patients sample. Main diagnostic categories found in patients with minor crimes included unspecified psychotic disorder, depression, susbtance abuse disorders and schizophrenia, seen in 31%, 19%, 17% and 14% respectively of the subgroup. Patients with subtance abuse disorders included 5 patients with alcohol dependence (3 of whom had presented with withdrawal delirium) and 2 patients with opioid dependence. Out of two patients with adjustment disorders, one was with brief depressive reaction and another with mixed anxiety and depressive reaction. Two main diagnoses found in patients involved in major crimes were schizophrenia (43%) and depression (17%). There were very few patients suffering from neurotic disorders.

Twenty seven male patients had psychiatric illness before committing the crime. Diagnostic distribution of this group of patients along with with nature of crime committed is given in table 5. These patients had been involved in both major and minor crimes. Four of the 7 patients with schizophrenia were involved in murder cases. However, due to a small sized sample no definite conclusion can be drawn.

Out of 4 female patients, two suffered from schizophrenia, one from bipolar affective disorder and one from generalised anxiety disorder. They had been involved in crimes like murder (1patient), drug trafficking (2 patients) and flesh trade (1patient). The illness preexisted the crime in three of these patients.

DISCUSSION

Attendance at the psychiatric facility in the prison consisted mainly of patients with psychotic disorders and depression, which reflects referral pattern from the primary care facilities. A high proportion of unspecified psychotic disorder was seen in the patient sample, especially in those involved in minor crimes. This group of patients had a shorter duration of stay in the prison and only limited information was available about their behaviour in prison, whereas duration of stay in prison was much longer in the patients involved in major crimes and often a longitudinal report about their behaviour in the prison was available. Lack of adequate information was responsible for higher number of unspecified diagnoses in patients involved in minor crimes.

Alcohol and drug related problems consisted of withdrawal syndrome and were seen in cases arrested shortly before the referral, and these were the ones who had been involved in minor crimes.

Adjustment problems, acute depression and acute anxiety are quite common in the prison setting, especially during the initial period of confinement in the prison, though these may not always come to notice (Gunn et al., 1991; Fido & al Jabally, 1993). These are also probably ignored or not considered worthy of psychiatric referral, because these are not recognised as problematic in behavioural sense. This may also be the reason for a very low number of such patients in the present study. Many of these patients improve spontaneously in a short period, as the prisoner adjusts himself to the environment, and hence does not come to the attention of the psychaitric facilities. Some of them get withdrawn on being imprisoned, because the support from family or friends and contact with over the counter drugs and family physician are often missing in the prison. Only the severe cases, especially with behavioural manifestations or suicidal risk are sent to the psychiatrist Psychotic patients are most likely to come to notice of the jail authorities because of their behavioural disturbances and hence reach the jail psychiatrist more often.

True clinical picture is often difficult to get because of varied reasons like absence of family members to provide information about the patients, motivational factors, and limitations imposed by the law restricting

observation of the patient. Due to constant contact with legal process and criminals in the prison, the patient may not provide correct information and try to mislead the psychiatrist, also resulting in higher number of unspecified diagnoses. There is definitely a need to expand the psychiatric services for the mentally ill offenders because otherwise mental illness is likely to delay the legal process, and hence many times prolonging the stay of undertrials in the jail (Robertson et al., 1994). This would help in early identification and treatment of the disorders.

Diagnostic pattern at the prison facility is in fact comparable to that at the psychiatric services of the Institute of Human Behaviour & Allied Sciences, Delhi, where also around 70% of the patients are of schizophrenia, mania and other psychotic disorders (Hospital Statistics IHBAS, 1996). Of course the number of unspecified diagnoses is not so high in institutional psychiatric settings. If the patient data is compared with some of the general hospital statistics reported earlier from India (Mahendru, 1979; Wig et al., 1978; Chadda et al., 1992), though the figures for psychotic disorders are comparable, but neurotic disorders are quite under represented in the jail sample.

One more issue is of prison environment which frequently inteferes with treatment and improvement. The so called psychiatric inpatients' unit in the present study was not like a hospital ward since it was just a collection of prison cells, isolated from the main prison as well as other units of the prison hospital. Due to security reasons and jail manual, many of these patients need to be kept locked for long hours in the cells often with no round the clock observation, defeating the purpose of psychiatric treatment (Gunn and Taylor, 1993). The prison environment thus interfered with improvement in patients who were admitted in the concerned psychiatric unit. Among the improved schizophrenic patients after they were shifted from prison hospital to the main prison, there were frequent relapses.

Substance abuse is another common problem seen in the prison. The commonest problem related to substance abuse and seen in the psychiatric unit was withdrawal syndrome which developed after arrest due to non availability of the drug being abused. Such cases need to be screened at the time of arrest. Patients with mental retardation is another category needing special facility, because they are likely to become a target for bullying and exploitaton.

To conclude, psychiatric services need to be developed properly in the prison set up considering the enormous psychiatric morbidity in the inmates.

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REFERENCES

Chadda, R.K., Shome, S., Thakur, K.N. & Bhatia, M.S. (1992) Morbidity patterns in a general hospital psychiatric unit adjoining a mental hospital. *Indian Journal of Social Psychiatry,* 8, 52-56.

Fido, A.A. & al-Jabally, M. (1993) Presence of psychiatric morbidity in prison population in Kuwait. *Annals of Clinical Psychiatry,* 5, 107-110.

Gottlieb, P., Gabrielsen, G. & Kramp, P. (1987) Psychotic homicides in Copenhegan from 1959 to 1983. *Acta Psychiatrica Scandinavica,* 76, 285-292.

Gunn, J., Maden, A. & Swinton, M. (1991) Treatment needs of prisoners with psychiatric disorders. *British Medical Journal,* 303, 338-341.

Gunn, J. & Taylor, P.J. (1993) Forensic psychiatry. Oxford : Butterworth Heinemann.

Hodgins, S. & Cote, G. (1990) The prevalence of mental disorders among penitentiary inmates. *Canada's Mental Health,* 38, 1-15.

Hospital Statistics, IHBAS (1996) Institute of Human Behaviour & Allied Sciences, Delhi.

India.

Mahendru, R.K., Srivastava, R.P. & Sharma, D. (1979) Mental health clinic in a teaching general hospital : some initial experiences. *Indian Journal of Psychiatry*, 21, 262-266.

Robertson, G., Dell, S., James, K. & Grounds, A. (1994) Psychotic men remanded in custody to Brixton Prison. *British Journal of Psychiatry*, 164, 55-61.

Teplin, L.A. (1990) The prevalence of severe mental disorder among male urban jail detainees : comparison with the epidemiological catchment area program. *American Journal of Public Health*, 80, 663-669.

WHO (1992) The ICD-10 Classification of Mental and Behavioural Disorders : Clinical Descriptions and Diagnostic Guidelines. Geneva : World Health Organisation.

Wig, N.N., Varma, V.K. & Khanna, B.C. (1978) Diagnostic characteristics of a general hospital psychiatric clinic. *Indian Journal of Psychiatry*, 20, 262-266.

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