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Carceral Psychiatry

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Introduction

Psychiatry, as a discipline, consists of individual practitioners, professional bodies, published texts, nosological categories, diagnostic instruments, therapeutic technologies, and specifically designed spaces oriented towards the therapeutic regulation of troubled persons. Since its emergence at the beginning of the nineteenth century, psychiatry has been closely aligned to biopolitical objectives and governmental attempts to manage (sub-) populations through processes of classification, discipline, and punishment (Foucault 1975 [1991]). State-sponsorship has enhanced psychiatry's cultural legitimacy and institutional authority, affording the discipline with significant administrative as well as political power. Psychiatry's ability to produce medico-scientific knowledge about the human mind as well as develop therapeutic technologies capable

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of making individuals more sceptical to self-regulation, meanwhile, has offered governments an ethical basis and practical means to manage its most troubling citizens (Miller & Rose, 1994). The close symbiosis between psychiatric activity-knowledge-power and State attempts to manage troubled persons manifests acutely within the genealogy of carcerality.[1]

Prior to the nineteenth century, 'mad' people in Europe were mostly treated similarly to 'criminals'—they were chained in dungeons and left to rot (Foucault 1965 [1988]). Towards the end of the eighteenth century, 'madness' and 'criminality' began to be conceptually separated by the emerging disciplines of psychiatry and criminology. As the 'mad' became categorically distinguished from the 'bad', specially-designed institutions of containment and isolation emerged to manage these distinct sub-populations—the asylum and the prison (Cooter, 1976). Asylums and the mad were the dominion of psychiatry, while prisons and the bad were criminology's territory. During the nineteenth century, the network of asylums and prisons greatly expanded through state-sponsorship. In England and Wales, for example, there were approximately 5,000 people housed across 21 asylums in 1847, but by 1914 there were over 100,000 contained within 102 public asylums, a figure that rose to over 125,000 people by 1930 (Rutherford, 2003). This rapid escalation in the confinement of 'mad' people meant that many asylums were overcrowded, with conditions denigrating and severe malpractice proliferating (Wright, 1997). The mistreatment of the 'mad' became a source of controversy by the mid-twentieth century, one that snowballed during the 1960s and 1970s into a forceful deinstitutionalisation movement that called for a closure of asylums and a move towards care in the community. The treatment of imprisoned people, however, was not the subject of such moral outrage and the status of prisons as an essential social institution went largely unchallenged for a discussion on prion abolition discourse see McBride [2018]).

[1] In this chapter I use 'carceral' to refer to the totality of the prison system, including prison policies, physical prison infrastructure, prison rules and protocols, and the actions-knowledge-power of prison staff. 'Carcerality' is used to refer to how this complex system operates to control and discipline prisoners.

Large-scale closure of asylums across the UK began in the 1980s as a radical shift in practice occurred—one that emphasised the human rights of people experiencing mental ill-health and demanded care and support within community-based settings. As deinstitutionalisation took place, the number of people imprisoned rose rapidly (for an in-depth discussion on the relationship between deinstitutionalisation and prison population figures see Ben-Moshe [2017]). Between 1900 and 2017 the prison population in England and Wales quadrupled, with around half of this increase taking place since 1990 (Sturge, 2020). As the prison population was growing, so too did concerns about the number of people in prison experiencing mental disorder and illness. This is reflected in the raft of policy documents published since the 1990s dedicated to the classifying and enumerating 'mentally disordered offenders' within the prison system as well as the development of technical solutions to manage this 'dangerous' (sub) population (Home Office, 1999, 2002, 2005a, 2005b). In the face of a swelling prison population, many of whom were said to have complex mental health needs, the British government drew heavily on psychiatric knowledge and technologies to advance the therapeutic reform of prison and enhance the rehabilitative capacity of prisons (McBride, 2017a). Such therapeutic reforms were ethically legitimised through claims of scientificity and morally justified as attempts to improve prison conditions and reduce danger to prisoners and staff (McBride, 2020).

The effect of therapeutic prisons reforms have been shown to be wide-ranging. Prison staff are trained to be more 'psychologically aware' and attuned to discourses of recovery and risk; while an increasing number of mental health experts—occupational therapists, mental health nurses, social workers, psychologists, psychiatrists—are employed in prisons to assess and treat prisoners (McBride, 2017a). Prison establishments have been refurbished, and new ones designed, to be therapeutic resources capable of assisting imprisoned people to recover from mental ill-health (McBride, 2020). As a result, psychiatric diagnoses and therapies have become increasingly fundamental in matters of criminal sentencing, sentence conditions, parole, and prison recall (Pilgrim, 2001; Reddy, 2002). Ultimately, this enmeshing of psychiatric knowledge and activities within carcerality has emboldened the micro-power of psychiatrists, and

other mental health professionals, working within prisons and afforded them considerable authority over the lives of imprisoned people. Yet, despite governmental optimism in psychiatry's capacity to effectively reimagine prisons, therapeutic reforms have been shown to be riddled with ontological and epistemological contradictions as well as technical limitations that render such gains implausible (McBride, 2020). Rather than reform prisons into spaces of care and support for troubled prisoners, therapeutic reforms have deeply implicated psychiatry in the punitive and disciplinary logic of carcerality (McBride, 2017a). Yet, to date, there remains little critical analysis of the role of psychiatry within contemporary carcerality. Furthermore, little attention has been paid to how psychiatry shapes the lives of imprisoned people.

In this chapter, I attend to these identified gaps. First, I offer a critical analysis of contemporary psychiatric discourse on 'prison psychiatry.' In so doing, I outline how the irreconcilability of prison psychiatry and the acculturation of psychiatrists to the carceral logic affects the lives of imprisoned people. I then go on to describe these effects in greater detail through the narratives of formerly imprisoned men. By recounting carceral clinical encounters, I show how psychiatry is explicitly experienced by imprisoned people as a coercive agency of power. To conclude, I argue that a semantic shift away from 'prison psychiatry' to 'carceral psychiatry' is required in recognition of the complex entangling of psychiatric activity-knowledge-power within contemporary carcerality.

A Methodological Note

In this chapter I have adopted a bricolage approach, premised on the analysis of a multitude of 'texts' from a range of sources (Yardely, 2008). The primary texts analysed here include contemporary psychiatric discourse on 'prison psychiatry' (published after 2000) and the transcripts of interviews with five former prisoners. The interview transcripts were generated as part of an ethnographic study I undertook of prison mental health policy and practice (2011–2014), which involved me attending a mental health unit in a high security prison and

working closely with a peer-support organisation led by former prisoners. I conducted approximately 30 interviews with the former prisoners, mental health service users, psychologists, psychiatrists, prison officers, governors, and policy makers I met along the way (for more on this methodology see Browne and McBride [2015] and McBride [2017b]).

The analysis presented is critical. My reading of 'prison psychiatry' is heavily influenced by the works of Foucault (1975 [1991]), Miller and Rose (1994), and Rose (1998), which direct us to consider how the discipline of psychiatry as a branch of knowledge and social practice is orientated towards untroubling troubled people through techniques of control and self-regulation. My reading of 'prison psychiatry' is further influenced by scholars such as Davis (2003), Wacquant (2009), and Scott (2013) who draw attention to the ways in which contemporary prison systems operate to manage (sub-) populations classified as troubling within capitalist societies (i.e. the poor, people of colour, migrants) in ways that are harmful for the individual as well as devastating for the communities they come from/return to. Finally, this analysis builds on the work of Brown (2008) and McBride (2017b) who highlight the importance of listening to prisoners' accounts of their experiences and undertaking scholarship with the implicit aim of challenging the dehumanisation of imprisoned people. As such, the critical analysis presented here is attuned to the complex permeations of carceral power that riddle through 'prison psychiatry' and how such permeations intersect across the lives of imprisoned people.

'Prison Psychiatry'

Irreconcilability, Acculturation and Harmful Effects

In the mid-twentieth century, Powelson and Bendix (1951) published a study on '*Psychiatry in Prison*.' An in-depth discussion of their article here offers a valuable watermark to critically reflect upon contemporary discourse on 'prison psychiatry.' Writing within the context of the USA, Powelson (a psychiatrist) and Bendix (a sociologist) saw the treatment of prisoners as one of the 'major social problems of our time' (1951:

73). The authors delineated what they considered to be the distinctiveness of the liberal rehabilitative approach of medical staff and the disciplinary approach of custodial staff, describing how these contrasting occupational orientations produce constant tension in everyday practice. Powelson and Bendix highlight how these competing orientations generate differing perceptions of prisoners. On the one hand, the norms of psychiatry, they suggest, places emphasis on the mental health of the person, creates recognition that actions are determined by a person's emotional history, and requires the suspense of moral judgement of a person's actions for the sake of therapeutic success. On the other hand, the norms of custody frames prisoners as cunning malingerers (particularly in relation to mental health issues) whose actions reflect their depravity and, as such, necessitates punishment for any violation of prison rules. The authors also stress that custody staff outnumber mental health staff and have the final say in prison decision-making, which gives custody ultimate 'power over' prisoners. Consequently, Powelson and Bendix argue that there is an inherent *irreconcilability of psychiatric practice within carceral space* since all therapeutic work in prison is inflected by securitised operational paradigms and the punitive staff culture, which subordinates prisoner 'health' in favour of order and discipline.

Powelson and Bendix go on to argue that irreconcilability of psychiatry in prison means that psychiatrists who hope to promote rehabilitation and health "cannot, in fact, pursue this goal" since the physical conditions and the mental climate surrounding medical and psychiatric aid within prisons "make ordinary standards of medical and psychiatric practice completely inapplicable" (1951: 81). Reinforcing this claim the authors suggest the prevailing occupational culture of custody frames compassion as a weakness and hardness as a strength, meaning the characteristics of good psychiatric practice are devalued in prisons. Powelson and Bendix polemically outline how this leaves prison psychiatrists with four options: (1) become an officer, and stop pretence of practicing medicine; (2) adopt custody's punitive attitude towards the prisoner; (3) practice psychiatry without appreciation of the futility of this work; or, (4) become aware of the irreconcilability of practicing psychiatry in prison and leave the prison to practice elsewhere. The authors feel many

psychiatrists will come to tolerate the gulf between aims and actual practice of psychiatry in prison and, over time, begin to adopt the prevailing attitudes of custody staff (i.e., that prisoners are morally weak malingerers who are criminals by choice or due to personal failure). The *acculturation of psychiatrists to the norms of carcerality* means that in many respects psychiatrists practicing in prisons come to act in the best interests of institutional order and discipline as opposed to the health needs of prisoners.

Powelson and Bendix argue that the irreconcilability of prison psychiatry and the acculturation of prison psychiatrists affects prisoners in numerous ways. First, due to the prevailing attitudes among custody staff, any application to psychiatry may be held against prisoners as further evidence of their malingering tendencies. Second, the dispensation of pharmaceutical drugs is limited and clinical encounters curtailed due to security protocols, which severely erode the quality of care provided. Third, the enmeshing of prison psychiatry within the carceral logic means that prisons are offered 'therapies' that typically have punitive or disciplinary implications (at the time Powelson and Bendix indicate this included: electric shock, insulin shock, fever treatment, hydrotherapy, amytal and pentothal interviews, cisternals and spinals). As such, Powelson and Bendix indicate that the enmeshing of psychiatry within the carceral logic results in many prisoners being dissuaded from seeking psychiatric assistance, denied the care they require, or subjected to ethically questionable 'treatment.' The critical points raised by Powelson and Bendix provide a useful benchmark for reading through contemporary psychiatric discourse on 'prison psychiatry.'

Contemporary Psychiatric Discourse on 'prison Psychiatry'

Almost 70 years on from Powelson and Bendix's study, prison psychiatry is considered "an important part of institutional operations" (Collins et al., 2017: 34). Many contemporary commentators frame the prominence of psychiatry in prisons as an inevitable consequence of the high level of mental disorder and illness among imprisoned people.

Indeed, it is routinely stated that around two-thirds (60–80%) of people serving a prison sentence have a mental disorder and/or engage in substance misuse (see Konard et al., 2007, 2012). The wide-scale psycho-pathologisation of prisoners relates to changes in the psychometric assessment of prisoners (Appelbaum et al., 2001). Historically, surveys of psychiatric morbidity among prisons used narrow definitions of mental illness, which focused on major depressive disorder, bipolar disorder, schizophrenia, and other psychotic disorders. At the turn of the twentieth century, psychometric assessments were broadened to include other diagnoses, most notably (and controversially) personality disorder (McBride, 2017a). The effect of this was a doubling of the percentage levels of prisoners said to have a mental health condition (Appelbaum et al., 2001). This re-classification of a large proportion of prisoners as mentally disordered/ill greatly increased the ambit of psychiatric authority within prisons and amplified the salience of psychiatric knowledge, classification, and intervention in penal policy (McBride, 2017a). As such, contemporary psychiatric discourse is foreshadowed by a view of prisoners as inherently troubled persons with a plethora of psychiatric needs. This has resulted in considerable focus being placed on technical solutions, such as developing standardised psychiatric assessment on committal and the development of psychiatric interventions tailored to the prison context (see Konrad et al., 2007, 2012). Thus, changes in assessments procedures, which radically increased the rates of prisoners categorised as in psychiatric need, have led many contemporary commentators to sidestep the 'social and political' question of whether people with mental disorder/illness should be detained in prisons and focus on how best to 'treat' this troubled (sub-) population.

The normative operational principle underpinning contemporary psychiatric practice in prisons is the 'principle of equivalence', which asserts "therapeutic levels of care in the community should prevail in the care of incarcerated mentally disordered persons" (Konard et al., 2007: 111). As such, psychiatric care in prison is considered most effective when delivered by a multidisciplinary team of psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, and other mental health professionals (Appelbaum et al., 2001). Yet, owing to the comparatively low levels, and variable standards, of prison mental health

services, most commentators are doubtful that most prisoners receive care that is appropriate and/or equivalent to that which is offered in the community (Konard et al., 2007; Till et al., 2014). Consequently, contemporary psychiatric care reasserts the theme of irreconcilability identified by Powelson and Bendix (1951), with many stressing how the 'uniqueness' of prison environments restricts the quality of treament provided (Till et al., 2014).

Contemporary commentators outline a range of institutional features that impair the practice of psychiatry in prison. System challenges, including limited healthcare budgets and overcrowding, are said to hamper the delivery of prison mental health services (Konrad et al., 2012). Rigid operational structures and tight security protocols, meanwhile, are identified as greatly affecting the delivery of psychiatric services. This is acutely apparent in pharmacy services, where the prescribing of psychopharmaceuticals is hindered by formula restrictions and dispensing procedures that are primarily geared towards preventing the diversion of medication for non-medical use (Collins, et al., 2017). Meanwhile, for psychiatric treatment to be effective within prisons it is acknowledged that custody staff have a role in supporting multidisciplinary mental health teams. However, collaboration between these different professional groups is often tainted by a lack of mutual respect, differences in occupational training, poor communication, and limited cooperation (Appelbaum et al., 2001; in line with the distinct orientations of psychiatry and custody described by Powelson and Bendix [1951]). The unique environmental constraints psychiatrists encounter within prisons are therefore acknowledged as eroding psychiatric practice in prison to the point whereby mental health services and supports are often rudimentary in comparison to equivalent services in the community.

Contemporary commentators highlight how psychiatric services in prisons are not just rudimentary, but also difficult to access due to custody status, concerns about confidentiality, fear of being perceived as weak or being seen as colluding with staff, confusion around treatment pathways, and concerns about staff qualifications (Collinset al., 2017; Till et al., 2014). Consequently, prisoners often only get treatment if they are perceived to be at risk of harm to self or others (Konrad

et al., 2012). Access barriers are further compounded by the nature of the prison environment, with separation from family, the threat of physical harm, and solidarity confinement identified as major stressors for prisoners (Appelbaum et al., 2001; Konrad et al., 2012). This potent mixture of rudimentary services, access barriers, and environmental stressors results in many people experiencing an acute deterioration in their mental health while in prison, which can lead to self-injurious behaviour and suicide (Till et al., 2014). However, rather than such insights leading to calls for the radical transformation of the carceral system, they are used to underscore the importance of providing effective psychiatric interventions to ensure the safe operation of penal institutions (Collins et al., 2017).

In line with the theme of acculturation thoroughly discussed by Powelson and Bendix (1951), many contemporary commentators indicate that the prevailing ethos of security and discipline within prisons leans on prison psychiatrists, tilting them to practices of surveillance and control. This can involve prison psychiatrists being placed "in ethically questionable territory" and being asked to "carry out psychopharmacological or other medical interventions for which there is no primary medical indication, in order to allow judicial proceedings and the penal system to run smoothly" (Konrad et al., 2012: 378). In addition, to being pressured to 'do something' about prisoners' behavioural problems, psychiatrists are commonly required to participate in disciplinary proceedings and "work with administrators in determining sanctions" (Collins et al., 2017: 35). Although these insights point to the nefarious ways psychiatric practice is pushed towards aiding institutional security to the detriment of individual well-being, unlike Powelson and Bendix (1951), contemporary commentators reflect little on how the securitisation of psychiatric practice may, or may not, result in the acculturation of psychiatrists to the prevailing carceral logic. As such, within contemporary psychiatric discourse there is an almost total absence of consideration of the *iatrogenic potentialities of carceral psychiatry*.[2]

[2] 'Iatrogenic' is used here to describe harm and illness caused by medical examination and/or treatment.

In fact, acculturation of psychiatrists to the prevailing logic of carcerality can be discerned *within* contemporary psychiatric discourse. For example, many contemporary commentators problematise prisoners experiencing emotional instability and psychological pain. Prisoners experiencing psychosis/depression are often identifed as potentially aggressive and violent, with prisoners diagnosed with antisocial personality disorder (claimed to be one-third of all prisoners) said to pose a particular danger (Konrad et al., 2012). Concerns around aggressive and dangerous behaviour have led to claims that "[s]ymptomatic inmates can impair the safe and efficient operation of a correctional facility" (Appelbaum et al., 2001: 1344). Appelbaum et al. (2001) go on to outline how the prison environment can overwhelm prisoners with limited coping skills and result in functional deterioration, infractions, and time on lock-up, which exacerbates the person's mental deterioration and leads to self-mutilation and suicide attempts. This, the authors Appelbaum et al. lament (2001: 1344), disrupts "the operation of the prison" and impairs safety and order within prisons by consuming time and resources. Such a perspective indicates acceptance that some prisoners who make suicidal gestures or attempts are manipulative, with those with "antisocial or sociopathic personalities […] more prone to manipulative attempts" (Konrad, 2012: 377). Collins et al. (2017) also warn that malingering and feigning illness is also a genuine concern. Manipulative prisoners, they suggest, exaggerate claims because it may benefit their legal situation, result in a lesser sentence, exonerate their guilt, support an appeal, enable them to access desired housing, entitle them to disability claims on release, enable them to avoid conflict, work, and disciplinary procedures, *and* to be prescribed medications. Consequently, the moralised judgement of prisoner actions, which Powelson and Bendix (1951) identified as integral to the culture of custody, is palpable within contemporary psychiatric discourse. This suggests that contemporary psychiatric discourse is uncritically adoptive of the logic of carcerality, to the point whereby the knowledge, practices, and technologies of psychiatry are unproblematically aligned with the operational aims of, and cultural tendencies within prisons. As Till et al., (2014: 180) suggest, the public health imperative of psychiatry is to improve

and protect the psychological health of prisoners *and* assist "their decision to lead law-abiding, useful lives after release" (Till et al., 2014: 180). As such, 'prison psychiatry' may be better labelled 'carceral psychiatry,' since psychiatrists in prison do not simply aim to alleviate psychological distress and improve mental health among prisoners, but *also* consciously work to maintain security and discipline within prison as well as make society safer by making individual troubled persons more socially obedient.

It is striking that within the contemporary psychiatric discourse reviewed here there is no meaningful consideration of the acculturation of psychiatrists to carceral norms and the potential this has for unprofessional behaviour, inhumane/degrading treatment, and the unnecessary application of force by mental health professionals. Nor is there any discussion of how psychiatric diagnosis, labelling and medication operates within the system of surveillance and punishment used to manage and discipline prisoners. Ultimately, this points to a dehumanising perspective of prisoners and a lack of concern with how prisoners experience their encounters with psychiatrists.

Prisoners' Encounters with Carceral Psychiatry

Iatrogenic Effects

The former prisoners who took part in interviews discussed how life within prison assaulted their mental health. Bruce, a former prisoner in his thirties, explained that he had adverse childhood experiences and in his adult life experienced depression. He had served multiple short sentences for non-violent crimes. He recounted one such sentence and how life in prison affected his mental health:

> I got lifted for two burglaries a lot of years ago. I admitted them when I was caught. How long did I spend on remand? Fourteen months. Of nothing. Smoking dope, taking drugs because at that time the only available option for you [on remand] was Maths and English GCSE, which I didn't want to do. I got four years that time, but I'd done fourteen

> months on remand, so I had ten months left, it takes about two months to get through the system and then there is eight months [left of your sentence]. [...] Eight months is basically no time to do anything and by that time you are demoralised by the fact that you've been in prison so long. You're doing nothing but drugs all day because that's what you do. You have no other reason to get up in the morning except go looking for drugs because, I got addicted to this heroin substitute.

Being imprisoned for over a year on remand (unsentenced) meant Bruce had few opportunities to fill his days with meaningful and fulfilling activities. This is because most education and employment opportunities as well as therapeutic services and supports are denied to prisoners on remand, who may (if found not guilty) be removed from prison at any time. As a result, the finite opportunities and resources that exist in prison are directed at sentenced prisoners and geared towards the conditions and length of their sentence. Ultimately, it was this lack of educational, employment and therapeutic opportunities that led Bruce to become addicted to a readily available psychopharmaceutical drug.

Conor, who was in his forties and had served a long sentence for a violent offence, explained how during his time in prison he witnessed fellow prisoners experience a deterioration in their mental health. He explained how the psychopharmacological technologies employed to treat prisoners could have iatrogenic effects:

> People either sink or swim [in prison]. I found education, I had my support from my network of friends and family. I seen guys who I thought were level-headed begin to manifest mental health problems, paranoia, I think it comes with the boredom of not being able to fill your time constructively. I seen them getting hooked on tablets. [Fellow prisoner] was on all kinds of medication. The next time I saw him years later he was blown up fat and didn't know what day of the week it was. Like he had a lobotomy or something. I think it was the tablets over the years.

For Conor, the overreliance on psychopharmacology as the primary treatment modality for prisoners not only harmed individuals, but

greatly affected the entire prison population by creating a cultural dependency on psychotropic medications:

> The drug culture in prison isn't heroin, cannabis and all that. The drug culture in prison is prescribed medication. Morphine tablets, any kind of opiate, that's the real problem in the prison system.

Chris, who was in his 50 s and served a long sentence for a violent crime, reasserted the point that many prisoners become addicted to psychopharmaceuticals while in prison. He argued that addiction to psychopharmaceuticals was a problem that is exported from prisons into communities, which results in people released from prison engaging in criminalised acts and getting sucked into a revolving door of short sentences:

> So it's actually starting in the jail and going [out into] community. So that's why I am saying [the prison system] creates monsters who come out. If you have the drugs in jail freely and you come out [and the drugs are] not there, what's the first thing on your mind to do? You go on the rob or break into houses to get what you want. There's fellas in there they're so hooked on drugs they go back in all the time because [drugs] is easier to get inside.

Acculturated Mistrust

Gerry, who was in his 40s and had been imprisoned for a non-violent offence, described how he felt the prevailing ethos of security and discipline within prisons leaned on mental health staff and bent their perceptions about prisoners. He described how the acculturation of mental health staff unfolded in practice:

> You have to recognise the insidious nature, the controlling nature of the institution. The poison touches every aspect of the institution such that it's very easy I believe for mental health staff to, and medical staff in general to, believe the worst of people because they hear it day-in, day-out from the prison officers.

Psychiatry's acculturation to the logic and norms of carcerality, Gerry felt, inevitably shaded the perceptions of psychiatrists, and led them to adopt the biases of prison staff. Consequently, he argued that many mental health staff came to view prisoners from an adversarial logic that framed prisoners as universally inclined towards dishonest and manipulative behaviour. The clinical mistrust of prisoners' intentions was further exacerbated by the perceived desirability of psychopharmacology, as Conor's experience shows:

> This guy used to tell me about the voices [he was hearing] and he was thinking of self-harming. So I was left in a bit of a dilemma here, what do I do with this guy? Couldn't very well tell the screws [prison officers], they are my enemy. […] So I went to the doctor […] and he said 'what can I do for you?' I said 'listen, I know a guy on the landing and he is speaking about self-harming and I think you maybe need to have a talk with him. I don't like going to the prison officers about it, I am telling you and I know you will keep this confidential.' He turned round and said to me 'are youse looking more tablets?' And I said 'listen, fuck off!' And got up and walked out. But I did see then the next day the psychiatric nurse took him off to the hospital building. […] I was very disappointed in the doctor's attitude. He thought we were playing the game. So a lot of the medical staff have to overcome their prejudice too.

An acculturated mistrust of prisoners' motives was considered to foreshadow most, if not all, clinical interactions between prisoners and psychiatrists. As Conor's tone indicates, this clinical mistrust is experienced as a fundamental betrayal, since it indicates an unfair bias that undermines the prisoners' capacity to act with integrity. Therefore, as Gerry suggests above, many prisoners come to view mental health staff as just another part of the carceral system that is intent on disciplining them.

Labels of Control

Former prisoners described how psychiatric diagnostic labels are used as a primary means through which psychiatrists exercise control over prisoners. Notably, personality disorder was identified as a label often used to classify prisoners considered troubling by prison authorities. As Chris explained:

> [The prison psychiatrist] said I had a personality disorder and then the [second psychiatrist] turned around to me and said 'no, you haven't.' And, [the third psychiatrist] said the same. I was originally diagnosed because it was easier to tag me than to admit that I couldn't be defeated. 'Cause I was stubborn, because I wouldn't speak to the ordinary prison officers and I wasn't a right run around of the mill of a prisoner. I just didn't like authority. So it was easy to tag me with something wrong with me. If you know what I mean? It was easy for their way of thinking. We can say he is a personality disorder or a mental case. […] It's their way of staying controlled.

For Chris, acts of non-compliance and anti-authoritarian behaviour lead prisoners to be 'tagged' with a diagnosis of a mental disorder; and that such psychiatric classification strengthens prison authorities' legitimacy to manage and discipline troubling prisoners. Gerry likewise experienced being labelled with a personality disorder as a form of punishment for his 'difficult' and 'challenging' behaviour. He explained how after 26 one-hour sessions with a psychologist he was recommended for a 'cognitive self-change' programme designed for men with a history of violent crime and that he challenged this decision because he was in prison for his first and only criminal offence:

> It went bad from the start, I brought out my pen and she said 'what are you doing?' I said, 'if you are going to memorialise what we say here, just to keep things right, I'll keep my own notes.' She took offence to this because I think she saw this as a challenge to her authority. […] She got very upset with me challenging why I was doing these courses and the interview was terminated. She basically blackmailed me that 'I could write you a bad report' and I said 'well I am writing this down

> myself so we can get an officer in as a third party witness'. She stormed off finally and after that interview, when I got the report, I found I had a personality disorder, which I didn't have before. Which really worried me because it was coming to the time that I would be due for my parole. This was far into my sentence. So what I had to do was see my solicitor about if we could get legal aid to get another psychologist in to write a different report to rubbish the first psychologist. But when I discussed it with my solicitor she said 'this is very bad. They've got you down here as a personality disorder'. And I said, 'well the outside psychologist we get what if he or she writes a report that agrees with the colleague?' The solicitor says, 'don't worry about it we pay them, they write what we tell them to write.' And I thought well the whole fucking thing is a racket. Of course, we got a higher psychologist in, trumped your woman's report with his report. Everything was sweet. […] As far as the personality disorder I believe I was given that label to suit your woman's ends, she wanted to punish me and this she thought would get me when she had the power to do it. […] They said I had a problem with authority. I don't think I had a problem with authority as such I think I had a problem with individuals in authority who I think were acting unjustly.

As Gerry's experience shows, mental health professionals have the potential to wield psychiatric diagnoses vindictively to satisfy their personal vendettas. Being labelled with a psychiatric diagnosis, particularly personality disorder, can have real and long-term consequences for prisoners since it will be considered a risk factor in relation to a person's release from prison (e.g., the person may be considered to pose a danger to others if diagnosed with anti-social personality disorder, or to themselves if diagnosed with borderline personality disorder). Ultimately, the threat of psychiatric labelling compels prisoners to moderate their behaviour in line with institutional rules and to comply with professional decisions even if they experienced them to be unjust. This underscores how the application of psychiatric diagnostic categories within prisons implicitly and explicitly aims to make prisoners more obedient and malleable to control.

Gerry noted that within the securitised logic of prison institutions people psychiatrically labelled are classified as a potential danger to the smooth operation of the institution. Gerry described how psychiatric

labelling, as a result, legitimised the mobilisation of security techniques of isolation, segregation, and surveillance, rather than illicit therapeutic responses:

> The nature of the institution is that anyone who shows any signs of having any problems, which may threaten the stability of the institution is simply dealt with in a draconian way because the values and the security of the institution are absolutely paramount. […] If it is even seen that [prisoners] might be in that frame of mind [where they might harm themselves or others] they will simply be moved out of the general population to somewhere where they can be kept an eye on.

Psychopharmacological Technologies of Control

Former prisoners identified psychopharmacological technologies as another primary means through which psychiatrists exercise control over prisoners. Bruce explained how life in prison affected him psychologically to the point that he sought medical support, which resulted in him being offered debilitating psychopharmacological medicine:

> I went to the doctors in [prison] a couple of times because I was agitated, I was wound up, I was anxious and they stuck me on this blooming Chlorpromazine [an anti-psychotic]! Do you what? They give that to everybody. But, see how crap it makes you feel. […] I am not saying I should've been given Diazepam [anti-anxiety medication], but it wasn't even an option. The thing is when you get Diazepam you can still carry on your normal everyday tasks, it just sedates you a bit. You don't feel crap. The stuff they give you, sometimes you do get the impression that they give you it and they don't care how you actually feel, how you carry out your daily duties, tasks whatever, just as long as you are calm.

Bruce recognised that the medication available to him, and other prisoners, was greatly restricted due to security protocols designed to limit the supply of highly addictive medications. As a consequence of the securitised logic underpinning pharmacy options, Bruce was offered medication designed to treat psychotic disorders, as opposed to the anxiety he was experiencing. He found the medication given to him to

have a pronounced sedative effect that resulted in drowsiness and tiredness. In this way, Bruce's experiences reflect how within the carceral logic debilitating psychopharmacological technologies are preferred by prison authorities as the effects of pacification produced align with operational demands for order.

Chris felt strongly that prisoners classified as difficult or disruptive were offered potent psychopharmacology to control their behaviour. As such, he felt psychiatric technologies were purposefully mobilised by prison authorities for their sedative, rather than therapeutic effects, in an attempt to control 'difficult' prisoners:

> When I was inside they tried to offer me every drug you could name. [They offered me] that liquid stuff, does your brains in. Calms ye right down, and you're sleeping all the time. I wouldn't take nothing. 'Cause I didn't need them. I could sleep perfectly. There was nothing wrong [with me] except I had a mind. And maybe that's what they didn't like.

Discussion

Since the 1990s, the British government has engaged in the unprecedent therapeutic reform of its carceral system, which has resulted in psychiatric knowledge, diagnostic categories, assessment instruments, and treatment technologies becoming embedded in prison policy and practice at an unprecedented scale (McBride, 2017a, 2020). Therapeutic prison reforms have been framed as morally pertinent because of psychiatry's claim to ethically driven practice that forefronts patients' health and well-being as well as the discipline's intervention modalities claim to scientificity. As such, therapeutic prison reforms have seductive liberal appeal because they claim the capacity to simultaneously protect and improve prisoner mental health, support prisoner rehabilitation and desistance from crime, *and* diminish the overreliance on negative security and disciplinary measures within prisons. In this chapter, I have shown how contemporary psychiatric discourse rearticulates this optimism in the capacity of therapeutic knowledge and technologies to make prisons less harmful and more rehabilitative. Consequently, the ongoing

failings of prison mental health care are said to be due to systemic factors and the chaotic, needy and manipulative actions of prisoners. As such, contemporary psychiatric discourse is predominately orientated towards providing practical professional advice on how to negotiate the challenges of the prison environment, and to developing technical solutions to overcome the irreconcilability of psychiatry in prison.

Yet, through the narratives of former prisoners I have shown how the practice of psychiatry in prisons is unable to escape the effervescent securitised logic and punitive norms that permeate the carceral system. Consequently, psychiatrists become intimately embroiled in the control and disciplining of prisoners. As such, I argue there is a pressing need to move beyond acritical descriptions of 'prison psychiatry' and the challenges psychiatrists practicing in prisons face; and a moral imperative to critically reflect on 'carceral psychiatry' and the implications of psychiatrists acting as agents of control and discipline within contemporary carceral geographies. Moving forward there is thus scope for an intellectual project aimed at examining the heterogeneous permutations through which psychiatric activity-knowledge-power is contextually adopted and adapted to carceral logics of security and discipline. This will provide an understanding of the diversity of processes and practices through which psychiatry upholds and magnifies carceral power over troubled persons.

Such an intellectual project will reveal the extent to which carceral psychiatry operates to legitimise the carceral system as a site in which troubled people can/should receive therapeutic care and support. This will enable detailed considerations of the degree to which contemporary psychiatric discourse encourages cultural and financial investment in carceral systems. Further critical reflection on carceral psychiatry must thus be orientated to the ways in which therapeutic reforms legitimise the expansion of carceral systems and divert finite public funds away from housing, education, employment, health and welfare services in the community. Ultimately, there is a need within contemporary psychiatric discourse, and beyond, to consider how the activity-knowledge-power of carceral psychiatry emboldens the punitive capacity of the state, while simultaneously distracting from non-carceral measures capable

of reducing the social inequality and marginalisation implicit in the biographies of people sent to prison.

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