Mental illness and prison

Health & Medicine, Disease

From the 1960’s to the 1980’s, the deinstitutionalization movement demanded that the mentally ill be treated in the community, using new drug therapies that appeared to control even the most extreme behaviors of the mentally ill. This liberation of psychiatric patients was reinforced by court decisions that awarded certain legal rights to the emotionally ill. But few community-based programs were developed to treat psychiatric patients effectively. Released to the community without adequate support and treatment services, the mentally ill gravitated to criminal confinement facilities for offenders, particularly the jail but also to the prisons of the United States.

It is estimated that about 15 percent of offenders imprisoned at any time have severe or acute mental illnesses, such as schizophrenia, manic-depressionillness, and depression. Approximately 10 to 15 percent of persons with these three illnesses die bysuicide. Yet current treatment is extremely effective, if given. Prisoners tend to be in poor mentalhealthand about 80 percent of male prisoners and 80 percent of female jail inmates will, over their lifetime, have at least one psychiatric disorder.

The greater the level of disability while in prison, the more likely the inmate is to receive mental health services. In practice, proportionately more female prisoners use mental health services than do males, and whites are more likely to seek or secure prison mental health services than others. At least half of the inmates who need such treatment go without it (Sigurdson, 2001).

While the U. S. Supreme Court has not found that inmates have a constitutional right to treatment, it has ruled an inmate's constitutional right to medical treatment includes the right to treatment for serious emotional illness. The correction system is caught in the middle. Institutions are not required to provide services simply because their clients are criminals, and thus have shifted critical funds to other uses, such as increased security staffing. The threat of potential litigation has meant that some revision and provisions of mental health services for seriously ill inmates is necessary.

As the mentally ill become a larger segment of the population in jails and prisons, professionals in the mental health field became essential to the correctional administrators. The ratio of mental health practitioners to inmates remains much too low, there has been some progress. Because many institutions must deal with mental health issues on a priority basis, few to no services are provided for the majority who do not exhibit violent or bizarre behavior. It is a practical fact that in corrections " the squeaky wheel gets the grease" (Steadman, 1991).

For some inmates, the impacts of prison life overwhelm their usual coping patterns. Some factors that lead to prison psychosis include the routine of prison, fear of other inmates, forced homosexual behavior, assault and fear of assault, deteriorating in affairs and circumstances offamilyon the outside of prison and depression. When the psychological crisis comes, correctional administrators frequently transfer affected inmates to prison infirmaries or psychological treatment words, or initiate inmate transfer to a mental health system.

Long-term and intensive psychotherapy for mentally ill inmates is believed to be rare. Treatment for episodic mental crisis tends to remain at the first aid level in many states. Death rows do not usually contain a large proportion of a prison's population but subsume a disproportionate share of the per inmate cost due to the demands of observing, caring, and maintaining death row. That includes a lower staff-inmate ratio, mail processing, death-watch officer workload, closer custody during recreational periods and so on. Some inmates on death row become mentally ill and as such cannot be executed (Ford v. Wainright, 106 S. Ct. 2595, 1986).

The state has an additional burden of determining if the death-row inmate is insane, establishing some procedure to restore the inmate to sanity, and then certifying the sanity of the patient-inmate. Because this would be tantamount to a death sentence and not a favor for the inmate, it is unlikely mental health physicians would undertake that process alone or with any great enthusiasm. It remains for the states to develop procedures for identifying, diagnosing, treating, and certifying the sanity of death row inmates who claim to be insane (Steadman & Monahan, 1984).

For the extreme behavior cases, there are special units for more intensive treatment, such as the one in Washington State. That unit is a model of how to deal with extreme mentally and behaviorally disordered prisoners. Unfortunately, that facility can handle only 144 inmates. The figure is only about one-tenth of the commonly recognized population of inmates who could use more intensive mental health services. One quickly finds that only

the really severe cases are able to be referred to the Special Offender Center.

It appears that the relationship between crime and mental disorder has no real cause effect. It is essential for society to learn more about distinguishing between different kinds of mental illness and their impacts on safe and secure administration of correctional institutions. It is important to remember that the real link to look for is one that indicates the potential for harm to the mentally ill person and others. It may be a long time before such options are available to the already overcrowded corrections system in the United States (Wessely & Taylor, 1991).

There are two justifications that defendants can invoke in an attempt to relieve themselves of criminalresponsibilityfor a criminal act. The first is not guilty by reason of insanity and the second is incompetent to stand trial. In the first instance, offenders do not deny the commission of the act, but assert they lacked the capacity to understand the nature of the act or that it was wrong.

The second instance is based on the common law criterion that defendants must be able to understand the charges against them to cooperate with their counsel in the preparation of their own defense. The procedures for determining competency vary considerably among jurisdictions, but most make it a court decision based on psychiatric testimony. If defendants are found incompetent to stand trial, then they are usually committed to a mental institution until declared competent (Hans, 1986).

Psychiatric judgment of mental abnormality enters into the criminal law in three ways. Aside from fitness to stand trial and criminal responsibility, if an individual is convicted, psychiatry is often consulted in designing a custodial or treatment program for him or her. One problem in the use of psychiatry in the legal system is that there are vast and irreconcilable differences in the legal standards; fairness is achieved by responding to a specific act with a specific type of reaction while ignoring a mass of details about the accused.

On the other hand, in the mental health approach of psychiatry the wholepersonalityof the accused is relevant in determining the state's response to criminal behavior. Psychiatry is an appliedscience, but legal practice makes no such claim. Clearly, as long as a judge and jury have such important roles in the court process, convicted criminals cannot be treated primarily according to scientific standards. While it is customary for a judge and jury to participate in the legal process, we would find their dealing with matters of mental health bizarre and while the legal process is typically open to scrutiny by all people affected, the procedures of psychiatry are almost never made public. The types ofaccountabilityof the legal and mental health systems are quite different.

If a court correctly describes the facts of a case and chooses the correct legal response to these facts, the court is never held accountable for any negative consequences flowing from its actions, such as the suicide of a convicted offender. What ultimately happens to the convicted offender or whether the offender's family must go on welfare is not the court's concern. The judge is not bound to such utilitarian considerations. However the judge

is bound by law to a specific range of responses. Psychiatry, on the other hand, is responsible for how its decisions affect the individual in the future (Galliher, 1989).

With the advent of legal insanity and legal incompetence as defenses against criminal conviction caused the development of special asylums for the criminally insane, in most cases just another form of prison without due process protections. In more recent years those claiming to be not guilty by reason of insanity have been the subjects of considerable debate. President Nixon sought to have the not guilty by reason of insanity defense abolished. More informed criminologists point to such problems with the insanity defense as excessive media coverage, suspicion of malingering by the defendant, and conflicting and suspicious testimony by mental health professionals testifying for either the defense or the prosecution.

The insanity defense is used in less than 1 percent of all felony cases and of those only one in four are found to be not guilty by reason of insanity. One study found only the most emotionally and behaviorally disturbed defendants to be successful in their plea and that the successful petitioners had committed more serious offenses. The decision to acquit is more frequently made in court b y prosecutors, defense attorneys, and the judge, and less frequently by jury members. Persons acquitted by the not guilty by reason of insanity are generally found less likely than their cohort offenders to commit crimes after release (Hans, 1986).

Prosecutors often hope that those accused offenders acquitted through the plea of not guilty by reason of insanity will be institutionalized for a period

sufficient to reduce their dangerousness, and to provide both public and safety and some retribution. The debate continues. Perhaps the most reasonable solution would be to determine guilt first and then sift the issue of diminished capacity or insanity in that case to the sentencing or case disposition state. The American Psychiatric Association, following the attack by John Hinckley on the life of President Reagan, recognized that position.

As a response, by 1986, twelve states abolished the insanity defense entirely then created guilty by mentally ill statutes in its place. Under those statues, an offender's mental illness is acknowledged but not seen as sufficient reason to allow him or her to escape criminal responsibility. If convicted, offenders are committed to prison. Some states will provide mental health treatment in the prison setting, but others may transfer the offender to a mental health facility for treatment. In Georgia, defendants who entered insanity pleas but were determined guilty by mental illness received harsher sentences than their counterparts, whose guilt was determined in trial suggesting increased punishment for the disturbed offender (Callahan, McGreevy & Cirincione, 1992).

Persons with mental disability, such as mentally disturbed or disorders, were once scorned, banished, and even burned as evil. But in more enlightened times we have built backwoods fortresses for them to protect ourselves from contagion. They have been executed as witches, subjected to exorcism, chained or thrown into gatehouses and prisons to furnish a horrible diversion for the other prisoners. Before the Middle Ages persons with a mental illness

were generally tolerated and usually cared for locally by members of their own family, tribal system, or primitive society.

However widespreadpoverty, disease, and religious fanaticism seemed to trigger intolerance for any unexplainable deviation from the norm. The mentally disturbed were thought to be possessed by devils and demons and were punished harshly because of it. The first insane asylum was constructed in Europe in 1408. From that date until recently the asylum was a dumping ground for all the mentally disordered people that could be neither understood nor cured.

In the United States, one after another of the individual states responded to that compelling method of ridding society of misfits, and built numerous institutions during the mid 1800’s. The inflated claims of cures for mental illness could not stand up against the process of institutionalization and long-term commitments sometimes for a lifetime and not cures became the rules of the day (Ives, 1914).

Asylums became yet another invisible empire in America with the punitive excess and lack of care or caring ignored by society. “ Out of sight, out of mind” was the catch phrase of these unfortunates. With the discovery of tranquilizing drugs, these places became a place where patients were put into a controllable stupor, until a cure could be found. Because of longer and longer periods of institutionalization usually by family members finally got the attention of the courts. In the 1960’s the rights of all citizens, including the mentally ill and convicts, were being re-examined at every level.

The abuses in the back wards of the asylums were brought to light and the counter-reaction was extreme. In the early 1970's, state after state adopted policies under the Community Mental Health Act that swept the country. The essential goal was to release all inmates of the asylums who were not a clear and present danger to themselves and society. This act flooded the central cities of America with tens of thousands of mentally impaired street people and created poorhouses. The response by most jurisdictions has been to transfer the problem to the criminal justice system, filling the jails and correctional institutions of America, a process known as transintitutionalization (Arrigo, 2002).

There appears to be some confusion between physical disease and mental disease. Because physicians have made great strides in gaining knowledge about physical disease, it is assumed by some people that this is also true of physicians' knowledge about mental disease. That is the tendency is to apply the same standards of competence to both areas of practice, even though this is hardly warranted.

The distinction between crime and mental illness is unclear. Some of the writers assume that nearly all criminal behavior is a manifestation of mental disease. It seems that the reason for both of these ambiguities is that we really do not know what mental illness is, and that is the reason we cannot distinguish between mental illness and physical illness on the one hand and mental illness and crime on the other. It is unfortunate that the long indeterminate sentences often given to mentally disordered offenders reflect a fear that those committed might be a problem in the future.

It is the expectation that someone is capable of predicting criminal inclination that makes so questionable the programs for treating the mentally disordered. So, one can see the paradox of requiring psychiatrists to predict behavior and to attach a label to offenders, when that might result in an indefinite or even lifelong commitment to a mental institution for someone who is not really dangerous, such as a false-positive prediction. The individual is then labeled for custody and treatment in a special area within that institution. When you consider the wealth of folklore surrounding mental institutions, it becomes clear that a dreadful lifelong stigma accompanies the label of criminally insane. While the public remains upset by the gaping loophole in the net of justice, the courts continue to seek out equitable ways to deal with the offender who has diminished mental capacity.

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