

# Law and Psychiatry

## Offenders with Special Needs

WILLIAM H. REID, MD, MPH

**M**y father used to refer to some jobs as “God’s work.” This description applies to the efforts of the psychiatrists, psychologists, and other clinicians dedicated to helping some of society’s least-wanted, most-feared people. This month’s column is about working with patients in prisons or jails. I will not be discussing juvenile facilities, nor will substance abuse be a primary focus. In a future column, I will address outpatient and residential treatment for patients on probation or parole. For a more detailed discussion of the special needs of offenders and ways to address them, readers are referred to a forthcoming book, *Treating Adult and Juvenile Offenders with Special Needs*.<sup>1</sup>

### THE NEED

A great many alleged or convicted offenders suffer from significant mental illness. Their illness may have been a prominent cause of their offending behavior, may have contributed to their being arrested or placed in a special detention setting (such as a forensic hospital or the treatment section of a prison), or may be incidental to their offense. The needs of offenders who are mentally ill sometimes seem separate from the community’s need to be protected from their offenses, but the two come together in the recognition, diagnosis, treatment, and management of mental illness by clinicians in correctional settings.

A third kind of clinical “need” comes from the facility itself, especially a jail or prison. Mental hospitals are accustomed to psychiatric patients, since treating them is their primary mission. Correctional facilities have a number of different missions (detention, security, protection, rehabilitation) and serve a variety of populations. Such facilities must find ways to fulfill those missions, and thus they must balance issues of population behavior, illness, and safety in different ways than do hospitals. Helping incarcerated patients *per se* is important, but correctional mental health professionals are also part of a team that helps the institution run smoothly, decreases behavioral problems, and maintains safety and security.

### JAILS VERSUS PRISONS

Jails are different from prisons (although a few jails, such as one in New Orleans, are called “prisons”). The two are associated with different, although overlapping, effects

on, and causes of, psychiatric problems and disorders, and their diagnostic and treatment systems are often quite different. However, both jails and prisons value order as a means to achieve facility control, safety and security. Think about the response of a person with schizophrenia, depression, hypomania, borderline or schizotypal personality disorder, mild dementia, or mild mental retardation as he or she enters the environments described below.

**Jails** usually receive inmates directly, and often suddenly, from the community. People who are arrested have often had little or no preparation for the jail experience and may initially be intoxicated, dirty, injured, and/or disoriented. Jails are temporary detention facilities. Although the maximum stay is generally 1 year, most inmates are there for only days, or perhaps weeks, while awaiting bond or trial. Inmates who are actually sentenced to jail (as contrasted with those awaiting bond or trial) have committed minor crimes, generally misdemeanors. Jails contain a broad mix of offenders and alleged offenders, from those charged with very minor offenses to those awaiting trial for major felonies. An inmate may be housed in a dormitory, a group holding cell (“tank”), or a two-person cell. Arrestees are often uncertain about their lawyers, charges, trials (even whether or not there will be a trial), and possible sentences.

Health care facilities and services, including mental health services, vary greatly from one jail to another, with sophisticated services in some large cities but few services in suburbs and rural areas. Jail staff, especially in smaller communities, often have very limited mental health training. Jails are usually located in the community from which the inmate comes, allowing (at least potentially) more visitation, better liaison with local mental health services, local transition upon release, and geographic familiarity. Jail funding and governance are generally local, which may mean local awareness of funding

Dr. Reid is a forensic and clinical psychiatrist in Horseshoe Bay, Texas, and a past president of the American Academy of Psychiatry and the Law. He maintains an educational website, *Psychiatry and Law Updates*, at <[www.reidpsychiatry.com](http://www.reidpsychiatry.com)> and his most recent book, *A Clinician’s Guide to Legal Issues in Psychotherapy*, is available from Zeig, Tucker & Co, Phoenix, AZ. This column contains general clinical and clinical-forensic opinions which should not be construed as applying to any specific case, nor as any form of legal advice.

**Table 1. Some differences between jails and prisons**

Characteristics	Jails	Prisons
Preparation	None; usually sudden arrest	Pretrial and trial jail time
Length of stay	Days–weeks; 1 year maximum	1 year to life
Institutional “community”	Usually little	Present
Organization versus chaos	Often chaotic, confusing, noisy	Organized, stable, less noise
Inmate peer group	All types, crimes, allegations	More homogeneous; felons
Domicile	Dormitory, mixed “tank,” or cell	Cell
Mental health services	Often few, unsophisticated	Present, some sophisticated
Social/educational services	Few except for acute needs	Many, long-term needs
Mental health training of custody staff	Often little or none	Some to considerable
Ambiguity of situation	Often high (e.g., pending trial)	Low (legal issues resolved)
Location	In/near inmate's community	Usually far from community
Organized gangs, cliques	Usually limited	Routine
Danger of patient exploitation	Moderate	Moderate to very high
Governance and oversight	Local	State or federal

needs and problems, but widely varying levels of interest in and control over jail conditions. While some inmate gangs and other groups develop (e.g., among gang members who go in and out of jail), there tends to be less inmate intimidation than in prisons. The danger of organized violence is thus reduced, but inmate turnover decreases peer support as well.

**Prisons** are fairly stable communities. Their inmates are more homogeneous than those of jails; all have been convicted of felonies and all are sentenced to more than 1 year of incarceration. The inmates have had some preparation before arriving, time to adapt to incarceration in general, and weeks or months of experience with the judicial and correctional system before their imprisonment. The inmates' major legal issues are generally resolved; they have been found guilty and know how long they are likely to serve. They are usually housed in two-person cells with a consistent cellmate. Although often noisy, especially in intake sections, the prison environment is less chaotic than that of most jails. Correctional staff are likely to have more general training and more specific instruction about mental health matters. There is a system of health and social services which, although sometimes Spartan, includes full-time professional staff, educational opportunities, and health and mental health care. Prisons are funded and governed by state or federal agencies, which are likely to be more sophisticated and have better oversight mechanisms than the governing bodies of most local jails.

Prisons are usually located far from the inmate's home. Visitation can be sporadic and maintaining community ties (for both the inmate and service agencies) can be difficult. The stability of the prison community allows inmate groups, gangs, and hierarchies to develop; some are problematic or dangerous while others are potentially supportive.

Some of the key differences between jails and prisons are summarized in Table 1.

### VULNERABLE INMATES

It is often easier for inmates to hide their vulnerabilities in jails than in prisons. When the population doesn't change and one mixes with the same people for months or years, weaknesses and idiosyncrasies (e.g., of offenders with mental illness) surface quickly and are soon exploited. Prisons often have special sections for vulnerable inmates, but the inmates who are mentally ill may still be mixed with others who continue the exploitation. The other traditional “solution,” administrative segregation (solitary confinement), may be physically safer but can have substantial psychological consequences for, say, an inmate with depression or schizophrenia.

Because of their short detention stays, jails routinely lack both the formal “community” structure of a prison and a prison's informal sense of inmate stability. Some of the prison community structure is unhealthy, even dangerous (e.g., gangs, some racial cliques), but most is less stressful for most inmates than that in jails. In my experience, inmates with chronic mental illness fare much

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better, from day to day, in prisons than in jails. Prisons must deal with the long-term health and welfare needs of their inmates; jails rarely do.

## TYPES AND PRESENTATION OF MENTAL DISORDERS

With some exceptions, neither mental illness nor mental retardation is highly correlated with serious criminal behavior. However, individuals with some mental illnesses or mental retardation proportionately exceed the general population (and the general offender population) in exploitation by others to commit offenses, ease of apprehension and arrest, difficulty adapting to chaotic jail conditions, difficulty understanding their pre-trial or incarcerated situations, and exploitation and/or abuse during incarceration (by other inmates and occasionally by custody staff). There is considerable evidence that defendants with mental retardation, at least, have much higher conviction rates than other defendants, with some convictions probably being undeserved.

**Mood disorders** are notable for their association with suicide (although they are not the only source of self-injurious behavior) and for the probability that they will worsen in the correctional environment. They are at least as common in jails and prisons as in the "free" (non-incarceration) world, but the proportions of type and presentation are different. Morbidly depressed people rarely commit crimes and frankly manic ones are rarely sent to prison, but since most mood disorders are episodic (and depression and hypomania are occasionally associated with criminal behavior), correctional populations include the entire gamut of mood disorders.

**Psychotic (thought) disorders** such as schizophrenia are common in incarcerated populations, sometimes because of an association with a crime (in jails, more often with an alleged crime which may eventually be adjudicated without imprisonment) and sometimes because of inter-episode criminal behavior. Non-schizophreniform psychotic disorders such as delusional disorder and substance-related psychoses are well represented. Occasionally, a person with no prior psychiatric history experiences his or her first psychotic break in jail or prison.

**Mental retardation** is not usually a cause of serious criminal behavior, but it can lead to arrests for minor crimes or social misunderstandings, being more easily arrested than other criminals, higher conviction rates, exploitation (in jail or prison and outside, by criminals looking for an easily manipulated accomplice), and difficulty understanding and adapting to incarceration. Individuals with mental retardation frequently have limited mechanisms for coping with anxiety and frustration,

which may precipitate behavioral problems or severe depression.

**Brain damage** and other brain deficits are associated with confused, confusing, difficult-to-treat inmates. Pre-conviction damage is usually mild or moderate, since severe deficits are generally inconsistent with directed criminal behavior. Damage that removes inhibitions and decreases impulse control is often seen but is sometimes clinically subtle. Careful, corroborated history and neuropsychological testing routinely reveal such deficits in a significant portion of unselected inmate populations.

**Adaptive problems** are expected in both diagnosed patients and ordinary inmates. Some reach the level of adjustment disorder or even acute stress disorder. Prison staff and procedures routinely address new inmates' adaptation to incarceration and learning "how to do time," but most jails do not. Even healthy arrestees and inmates can develop painful, pathological, and sometimes dangerous mechanisms of adapting to what are, to them, the extraordinary stresses of incarceration. They should be treated when necessary, but not overdiagnosed.

**Impulse control disorders** are often paired with personality traits or disorders in prisons and treated as if they were part of an Axis II syndrome. In jails, where the inmate's behavior may be more closely compared to his symptoms before arrest and where neuropsychiatric evaluation may be part of a pre-trial workup, specific impulse-related diagnoses (such as ictal diagnoses or other brain disorders) are made more often.

**Non-antisocial personality traits and disorders**, especially those with characteristics that may interfere with the inmate's adapting to the jail or prison environment, or which may become more prominent (even self-destructive or psychotic) as a result of it, are common in jails and prisons. Adequate screening and observation is important (see below).

## MANAGEMENT AND TREATMENT ISSUES

### Screening and Recognition

All prisons and most jails have a screening process that is designed to identify, among other things, severe mental illness, suicide risk, medical problems, and personal characteristics that are likely to interfere with adaptation to jail or prison life. Screening in prisons is almost always more sophisticated than that in jails.

### Suicide

Suicide is a prominent issue in all correctional facilities. It can occur at any time, but is most likely just after arrest (e.g., in neighborhood lock-ups that have few

screening procedures or services), before trial, just after sentencing, and during times of extraordinary stress or fear (e.g., when being exploited or abused by other inmates). Suicidal behavior is not seen solely in depression, but also occurs in psychotic, confused, inadequate, and very anxious inmates. It often occurs with little warning during the acute stresses, losses, and other conditions associated with, for example, arrest (e.g., intoxication, humiliation, desperation, fear), anticipation of conviction or sentence, conviction itself, transfer or change in status (e.g., return to the "general population" after being in a protected environment), and threats from others. Self-injury that appears superficial or manipulative should nevertheless be reported at once and the inmate closely monitored until cleared by an appropriately trained professional.

Several experienced clinicians and authors have described a half-dozen steps that jails and prisons should take to prevent and control suicidal behavior and decrease the likelihood of inmate death—they work:

1. Suicide prevention training for both correctional and medical/mental health staff
2. Intake screening for suicide risk
3. Established procedures for mental health and medical referral and assessment
4. Effective communication among custody, mental health, and medical staff during both referral and management of the suicidal condition
5. Careful supervision and safe housing of suicidal inmates
6. Timely medical intervention following suicide attempts.<sup>2</sup>

#### Role of Custody Staff

Mental health issues can create both problems and opportunities for custody staff. It is in their best interest to deal effectively with inmates who are disturbed or have mental illness, and many staff members are quite good at recognizing and solving problems informally.

Experienced correctional mental health staff know that custody staff can be a great asset to both the clinician and the inmate. Custody staff should be treated with respect and asked for their counsel when appropriate, and their abilities and responsibilities should be valued. Most custody staff will respect the mental health staff in return, serving as valuable eyes and ears for clinicians and supports for impaired inmates.

All prisons and many jails provide some level of mental health training for custody staff; many prisons and a few jails have longer programs to prepare staff members for assignment to special mental health units. Such an

assignment can offer professional and career enhancement, additional pay, prestige, and other advantages. In a few cases, however, the chosen employees experience isolation, or even derision, from their custody staff peers.

#### Prominent versus Quiet Patients

Inmates with mental illness who stand out and cause problems quickly get attention (therapeutic or nontherapeutic). Those who are quietly psychotic or depressed are harder to recognize. The jail or prison may not see them as a "problem" (except perhaps in terms of suicide risk). Counselors and nursing staff, supervised by experienced psychologists and psychiatrists, should be generally aware of the entire inmate population in addition to screening new inmates and monitoring those with known mental illness, substance abuse, problems adapting, or mental retardation. Custody staff should be trained to relay requests for medical or psychological attention without delay, rather than deciding for themselves which requests are worthy of professional attention.

#### THE FINAL WORD

We haven't talked about treating severe antisocial syndromes themselves, the bent psyches that give rise to heinous, uncontrollable behavior. A very few clinicians (would that it were more) spend hours with inmates trying to unravel and change the causes of their violent or criminal behavior. Most of us don't, often because of the difficulty and frustration involved, the volume of other work that assails us, and our own revulsion and counter-transference.

A few years ago, my wife and I visited Georg Stürup, MD, former superintendent of the famous Herstedvester Detention Centre in Denmark, in his Aarhus home. He was retired and quite elderly, but still vitally interested in treating "untreatable,"<sup>3</sup> dangerous, and severely antisocial patients. As he pressed his old manuscripts and reprints into my hands, he seemed to be saying "Don't forget these people. They have no one, yet they *are people*. They are desperately lacking and in terrible pain. Those who understand them are so rare; you must not turn your back on them."

#### References

1. Ashford JB, Sales BD, Reid WH, eds. Treating adult and juvenile offenders with special needs. Washington, DC: American Psychological Association; in press.
2. Ivanoff A, Hayes LM. Preventing, managing, and treating suicidal actions in high-risk offenders. In: Ashford JB, Sales BD, Reid WH, eds. Treating adult and juvenile offenders with special needs. Washington, DC: American Psychological Association; in press.
3. Stürup GK. Treating the untreatable: Chronic criminals at Herstedvester. Baltimore: Johns Hopkins Press; 1968.