Mental patients in prisons

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Mental conditions usually affect cognitive, emotional and volitional aspects and functions of the personality, which are also functions of interest in law, as they are essential at the time of adjudicating guilt, labeling the accused a criminal, and proffering a sentence. A relationship between mental illness and criminality has, thus, been described and given as one of the reasons for the large number of mental patients in prisons. Whether this relationship is one of causality or one that flows through many other variables is a matter of debate, but there is no debating that prisons have become a de facto part, and an important one, of mental health systems in many countries. This paper deals with the issue of the relationship and provides estimates of prevalence of mental patients in prisons culled from many studies in different countries. It also provides some direction for the management of mental patients as they crowd correctional systems.

Key words: Mental illness, prisons, epidemiology, mental health systems

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The association between some mental conditions and an increased risk for criminal behaviour has been repeatedly reported. In a series of 100 murderers, 29% had a diagnosis of "psychosis" (21% of schizophrenia and 8% of affective disorders) and 35% had a diagnosis of substance abuse (1). Among alcoholics, the prevalence of violent behaviour is much higher than among non-alcoholics (2). Psychopathy is strongly associated with a high risk for criminal and violent behaviour (3). Factors that seem to mediate the interaction between mental illness and crime include gender (4), age (5), socio-economic status (6), previous criminality (7), and previous forensic psychiatric involvement (8). In a 30-year follow-up of a birth cohort in Sweden, men who had a mental disorder were 2.5 times more likely to have been registered for a criminal offense and 4 times more likely to have been registered for a violent offense, compared to men not mentally ill or intellectually handicapped (9).

The level of convergence, however, varies according to the mental condition. Firstly, there are mental disorders whose very behavioural manifestations are *ipso facto* criminal offenses, such as in the case of paraphilias, pyromania, kleptomania and others. In these cases, the relationship between mental disorder and criminality is one-to-one.

Secondly, disorders such as psychopathic personality, antisocial personality, borderline personality, pathological gambling, and impulse control disorders connote a criminological element, but the degree of convergence is not one-to-one, in that symptoms could be expressed without necessarily breaking the law. For example, alcoholism carries a high risk of law breaking in the form of victimization at the time of intoxication, and drug dependencies are known to lead to income-generating crimes in order to finance the habit, but only if the addicted person does not have the financial means to support it.

Finally, the level of convergence is less straightforward among some other mental conditions. For example, persons suffering from schizophrenia may get involved in serious unexplainable violent crime (10), and persons suffering from major depression may display violent behaviour against self or others (11,12). However, the relationship between these conditions and criminal offenses is not a one-to-one, as many mentally ill persons suffering from schizophrenia or major depression never commit a criminal offense, in spite of the high prevalence of these mental disorders in the general population.

Looked at from a different angle, it may be that the association between criminality and mental illness flows not from a causal relationship, but is only the result of inadequate health systems. Lack of adequate number of hospital beds and inexistent community alternatives would be expected to create pressures in the alternate systems of correction (13) and community crime of the mentally ill may be reactive and defensive within the context of exposure to victimization (14).

Finally, while the relative risk is elevated for some mental conditions, it should be remembered that, for public health purposes, the measure to be concerned about is the attributable risk. Despite a high relative risk, violence due to mental illness is not that frequent once all other causes of violence in society are taken into account. This risk has been estimated at about 3% and, when substance abuse and alcoholism are included, at about 10% (15). Other estimates place the risk at 4.3% (16) or as low as 1% (17).

Furthermore, when a mental condition is suspected in relation to a crime, the unstated assumption is that the condition *preceded* the crime, and hence, may have actually *caused* the crime. In reality, it could have been that the mental condition that was present much earlier in life was not a factor in the present crime, or the mental condition developed after the crime had been committed.

PREVALENCE OF MENTAL ILLNESS IN CORRECTIONS

Correctional psychiatry in the strictest sense refers to psychiatric practice in the corrections system (18). More

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amply, correctional psychiatry is the branch of forensic psychiatry that studies the incidence, prevalence, determinants and management of mental disorders in prisons, the response of correctional systems to the mentally ill offender, and the relationship between criminality and mental illness (19).

Reluctantly, prisons have accepted the mentally ill ever since their invention over 200 years ago. Despite multiple government commissions and voluminous parliamentary reports in many countries, and the introduction of several alternatives to care, the problem persists and appears to be getting worse. In many cities, the large number of mental patients in the local jails has made the jail a practical extension of the general mental health services. The trans-institutionalization of mentally ill persons from hospital to prisons has been documented in a plethora of studies that have also estimated their numbers at different points of the justice-correctional system (20).

In jails, also known as remand centres in some countries, research reports on the prevalence of mental illness date back many years, as do reports from longer term prisons. A systematic review of 62 surveys in 12 countries involving 22,790 inmates found that, among males, 26% were violent offenders, 3.7% had psychotic illnesses, 10% suffered from major depression and 65% had a personality disorder, of which 47% antisocial and, among females, 4% had a psychotic illness, 12% had major depression and 42% had a personality disorder, of which 21% antisocial (21).

About 7% of sentenced males, 10% of men on remand, and 14% of women in both categories had been affected by a psychotic illness in the previous year; and among women on remand, 75% reported neurotic symptoms, and 20% of men and 40% of women had attempted suicide at least once (25% of women in the previous year and 2% of women and men in the previous week) (22). Lifetime history of abuse of substances or dependence disorders has been estimated to be present among 74% of inmates, and about 37% had abused or were dependent on alcohol or drugs in the previous 30 days (23). Furthermore, among 104 sentenced inmates arriving at a therapeutic prison in England, 26% had Psychopathy Checklist-Revised (PCL-R) scores of 30 or more and were, therefore, identified as psychopaths (24).

Overall, prevalence estimates of mentally ill in correctional facilities vary widely, from 7% (25) to 90% (26). Many reasons have been given to explain these disparities, including methodological problems, type of institutions where the studies have been carried out, kind and size of samples used, and how mental conditions are defined (27,28).

Violence in prison is both against others and, frequently, against self. Most people die by suicide than from any other reason in prison and, given that the majority of suicides occur within the first days of detention in jails or remand centres, special precautions and screening methods are highly recommended (29). Substance misuse, previous suicidal behavior and single-cell accommodation were considered risk factors for suicide (30).

MANAGEMENT

Prevention is the best policy. To make sure that patients do not drift into criminal behaviour by virtue of need or because of symptomatology, mental health systems should be flexible enough to provide adequate number of beds in acute psychiatric units in general hospitals, rehabilitation beds in tertiary hospitals and a red of services in the community that provide treatment, support and social rehabilitation to patients and their families (31). The police, as the caregiver of first instance, should participate in efforts to decriminalize the mentally ill (32). In many situations involving mental patients, the police should also have legislative authority to redirect patients to psychiatric services in cases where criminal offences have been minor or to make sure that patients are routed to mental health courts as found in several large urban centres (33).

When prevention fails and mental patients end up in prison, correctional systems should have protocols for their management and treatment. From the start, and to follow a principle of equivalence, treatment options in prison should not be second to quality to similar services in the community (34) and should address both the immediate mental health needs of the inmate and, in communication with mental health systems in the community, develop adequate post-release plans. Consent to treatment and other ethical safeguards pertaining to psychiatric treatment and research (35) should be the same as those that apply in the community, and regulatory bodies or research watchdogs should exercise their authority in overseeing that these regulations apply behind the prison walls as well (36).

CONCLUSIONS

Jails are not only "the most important of all our institutions of imprisonment" (37); they are also the mental health asylums of our times by the number, the diversity and the complexity of cases among the mentally ill persons they serve (38). Jails also seem to have assumed part of the burden of treatment for substance abuse and alcoholism. Whether this is a more humane or even a more economical alternative to community interventions would be highly debatable.

Despite many efforts and initiatives to minimize the plight of the mentally ill in prison and to prevent deterioration and imprisonment and especially to prevent reincarcerations (39,40), their numbers do not cease to climb. Close cooperation among agencies, new service modalities and better treatment approaches may be necessary to stop the transfer of mental patients from hospitals to prisons. Given that back in the early 1800s and afterwards, in many countries, prisons were the usual place for mental patients in lieu of asylums, despite all that has been done, little seems to have changed and their plight remains the same. *Plus ça change, plus c'est la même chose.*

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