Commentary: Mentally Disordered Offenders in Prison—Old Problems That Still Require Solutions

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We commend Simpson *et al.* for addressing an important topic: the care and treatment of prisoners with serious mental illness. We welcome the authors' conclusions, but we identify some problems that can often frustrate attempts to improve services to this group.

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Simpson and colleagues[1] are to be congratulated for highlighting again a topic of great importance in forensic psychiatry. Within that part of the speciality that is responsible for the care and treatment of mentally disordered offenders, concern for the inmates' mental status should not be overlooked. Experience gained through work of this kind will be helpful and complementary to the role of expert witness, assisting psychiatrists in speaking with greater confidence and authority during testimony. The authors highlight the rising number of prisoners who have serious mental illness (SMI) and the disproportionate increase in the number of prisoners from ethnic minorities who have higher rates of SMI. They pose several questions that arise from these trends.

One particular minority group to which reference is made in the review is Canadian First Nations people. The authors discuss the challenges that the increasing number of inmates from First Nations groups represents for mental health services. They helpfully exclude personality disorders and substance misuse from consideration, in that these are better treated as separate topics. They include suicide and attempted suicide in prison, which is perhaps an important and related topic. They conclude that SMI is becoming more common in the prison population. They discuss the effects of imprisonment on SMI and find that these effects are less severe than postulated. They question whether treatment in prison is effective, concluding that particular problems arise when prisoners are returned to the community but lost to mental health follow-up.

The rate of serious mental illness among prisoners has been of interest since the specialty of forensic psychiatry started to develop a strong identity during the middle years of the 20th century. For example, an early study in Scotland[2] found significant rates of SMI in a Scottish prison at a time when the large Victorian psychiatric hospitals were still in existence and inpatient psychiatric beds were readily available. The process of deinstitutionalization has since led to an increased number of people who have SMI returning to the community without adequate follow-up. It is inevitable that some of these individuals will find their way to prison. Also, in view of considerable research that identifies that SMI increases the risk of certain types of offending,[3] it is to be expected that the number of persons with SMI in prison will be greater than the number in the community.

Jurisdictions vary considerably in whether an offender with SMI is more likely to be committed to prison or to a secure hospital. Jurisdictions also vary in the options for transfer of a prisoner with SMI to a secure hospital, if there is a clinical need to do so.

People in the community who have SMI often receive assistance from family and friends, but how can this support be replicated within a prison? Con-

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fidentiality and stigma are much more complex difficulties to deal with in prisons. Finally, can prisons ever be a safe and suitable location for the administration of medication without consent?

Forensic services could never meet the needs of all SMI prisoners and should not be responsible for doing so, since the bulk of offenders in custody with SMI are minor offenders who do not require specialist forensic care. Community services may be reluctant or downright unwilling to become involved with patients with SMI who have offended, even if the offense is minor.

In some jurisdictions, effective aftercare can be arranged when prisoners with SMI come to the end of their sentences and are not fit for release. The prison health care service may refer them to local hospitals in the same way as if they had a physical condition. Further organizational complications arise within a health service that is predominantly in the private sector, as in the United States. These hindrances help explain the failure of community aftercare that Simpson and his colleagues identify.

Another aspect of the stigma faced by the SMI inmate is worthy of mention. It is often believed that prejudice in mental health services against mentally disordered offenders is a recent phenomenon, but that is not the case. There is evidence that such discrimination goes back a long way. In Scotland in the mid-19th century, when the first modern cellular prison was commissioned, it was found from the outset that mental hospitals or, as they were known then, asylums, in the surrounding community were unwilling to accept prisoners for treatment who were deemed to be insane.[4] Another example of there being nothing new under the sun.

Despite these organizational challenges, the future, as Simpson *et al*. conclude, must ensure improvements in the quality of the mental health care of SMI prisoners. The challenges in working to achieve these advances are considerable and vary from one jurisdiction to another but, as the authors emphasize, they must be resolved.

References

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