

Psychiatric Stigma in Correctional Facilities

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While legislatively sanctioned discrimination against the mentally ill in general society has largely disappeared, it persists in correctional systems where inmates are denied earn-time reductions in sentences, parole opportunities, placement in less restrictive facilities, and opportunities to participate in sentence-reducing programs because of their status as psychiatric patients or their need for psychotropic medications. The authors discuss the prevalence of such problems from detailed examinations of several correctional systems and from the results of a national survey of correctional medical directors.

There are a number of articles in the literature about the negative effects of psychiatric diagnoses and treatment. In the 1960s, sociologists developed the "labeling theory" of psychiatric diagnosis, which held that the maladaptive behaviors of those diagnosed as suffering from mental illness stemmed from the expectations created by the diagnosis itself and the effects of institutionalization, not from any true "disease" in the medical sense.¹ While support for that theory as the major explanation for mentally disordered behavior has dwined

as underlying genetic and biological factors have been elucidated and the same behaviors have been documented in persons not previously diagnosed or treated,² stigma has clearly not disappeared. In fact, it may well have increased in some ways in the postdeinstitutionalization era as communities have had to deal with mentally disordered persons formerly sequestered away in hospitals.³ Steadman and Coccozza demonstrated in their follow-up of the patients released from New York's maximum security correctional mental health facility following the *Baxstrom* decision (all of whom were both ex-convicts and ex-mental patients) that newspaper reports of the subjects invariably referred to them as ex-patients rather than ex-cons.⁴

The courts and Congress have attempted to diminish the stigma. In cases from the 1960s, the Supreme Court held that criminalizing the status of being a

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narcotics addict violated the Eighth and Fourteenth Amendments to the Constitution⁵; and it came to a similar conclusion with respect to alcoholism.⁶ Courts have also struggled with the issues of whether or not alcoholism is a disease for reimbursement purposes.⁷ In passing the recent Americans With Disabilities Act (ADA)⁸, the Congress went further than before in protecting persons with disabilities, including mental disabilities, against discrimination in the workplace based solely on the status of being mentally ill.

In addition to such well-documented manifestations of reaction to stigma, such as zoning restrictions against community group homes and denial of voting and other civil rights⁹ and increased use of jails and detention centers to incarcerate mentally disordered persons who no longer meet criteria for involuntary hospitalization,¹⁰ many consider the most egregious example of discrimination to be the lack of medical insurance coverage for the treatment of mental disorders.¹¹

This paper will examine a different aspect of the problems caused by psychiatric diagnosis and treatment. Correctional systems have come under fire over the past two decades in the majority of states because of inadequate health care services for inmates. Class action law suits have called for major improvements in the identification and treatment of inmates with health problems,¹² which have been specifically extended to cover mental disorders.¹³ Although these suits have led to significant improvements in both diagnosis and treatment

of inmates, they also have had paradoxical effects, in which the diagnoses and treatments themselves have specific and negative effects on the inmates who were supposed to benefit from the improvements. Discrimination in correctional systems is often *de jure*, rather than *de facto*, as it now is in most of the rest of society. Examples from two correctional systems will be presented to illustrate the types of problems encountered.

System A

Under Department of Corrections (DOC) specific regulations in this system, untreatable aggressive antisocial inmates can be transferred to less restrictive sections of facilities or to less restrictive facilities but treatable, nonaggressive chronically mentally ill inmates cannot. Clinicians in the system have pointed out that a dangerous, brittle, potentially assaultive and unstable, but untreatable severe characterologically disordered inmate, antisocial type, can receive a psychiatric rating that does not impede institutional status advancement. However, an inmate who is more emotionally distressed but amenable to treatment typically receives a higher psychiatric rating, particularly when combined with a mild characterological disorder. These elevated ratings pose severe barriers to institutional advancement and to community placement. In this sense, an amenability to treatment, a positive prognostic indicator, prevents progressive program advancement within the DOC.

System B

As a result of a series of evaluations at the DOC's intake center, all inmates ini-

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tially are assigned numerical codes for security classification as well as for various potential needs for services they might have during their incarcerations. These needs includes educational, vocational, medical, and dental as well as mental health needs for psychiatric, substance abuse, or sex offender treatment. Inmates are encouraged to participate in correctional programs designed to address these needs by forfeiting potential time off their sentences if they do not take advantage of such programs when offered. In addition, the parole board rarely grants parole to an inmate who has not complied with DOC recommendations for mental health treatment. All the coding criteria except that for sex offenders are based on current levels of functioning; but sex offenders are labeled according to past criminal arrests rather than according to current psychological functioning, and thus remain labeled sex offenders regardless of their participation in treatment programs.

Case Example Mr. A was in the DOC after conviction of burglary, a crime that involved no contact with other persons. During his classification at the intake facility, it was noted that he had been arrested nearly 10 years earlier during a sweep of an area of a large city because of a serial rapist who was operating in that area. Over 80 men age 20 to 25 years were picked up for questioning during the sweep. The real rapist was subsequently caught and convicted, but because of his arrest for a sex crime 10 years earlier, Mr. A was classified as a sex offender. The DOC sex offender treatment program evaluated

him and found no evidence of sexual problems or need for treatment. But he was denied parole at his first eligibility specifically because of the record of sex offender classification without any evidence that he had received treatment for this "problem."

In addition to being held hostage to earn time and the parole board in ways that inmates not classified as in need of mental health treatment are not, there are other negative consequences in this system to being classified as having a mental disorder (apart from any behavior associated with the mental disorder itself). The classification systems themselves are confounded by nonclinical uses. For example, all inmates convicted of violent crimes are automatically classified as having a psychiatric disorder, regardless of the reasons for their violence.

Thus, although the U.S. Supreme Court has held that the status of having a mental disorder cannot be punishable by the criminal law and that classification as mentally disordered should not deprive an inmate of basic due process rights, mere status as chronically mentally ill or as a sex offender (a category based entirely on past criminal history but deriving its authority from presumed mental health needs) can and does result in deprivation of liberty for inmates so labeled.

In addition to negative consequences of being classified as being in need of mental health treatment, the treatment itself has directly negative consequences in System B. Because of lack of nursing staff at many minimum security prisons

and camps as well as the boot camp (which provides the only way in which first-time, nonviolent offenders can get their sentences significantly reduced) inmates taking psychotropic medication may not be transferred to such facilities. This restriction places mentally disordered inmates, already at a decisional disadvantage, in an impossible bind. If they take prescribed medication, they are rendered ineligible for many less restrictive environments within the correctional system; whereas if they reject the treatment, they often deteriorate as their disorders recur, and they are still denied less restrictive placement because of their behavior. It is a system not calculated to build therapeutic relationships with mental health professionals.

Methods for the National Survey Component

To determine if similar problems exist in other correctional systems, survey questionnaires were sent to the medical directors of departments of corrections in each state and the District of Columbia. A second mailing was sent to non-responders, and telephone follow-up resulted in a 100 percent response rate.

Results

Forty-eight of the 51 respondents reported that psychiatric diagnosis at the time of admission to their DOCs affects initial facility placement, and 47 reported that psychiatric diagnosis affects subsequent placement. Despite the importance of psychiatric condition, only 13 respondents reported that their DOCs

have formal psychiatric classification systems (Table 1). Seventeen states reported that they use psychological testing exclusively for correctional classification, and another 17 reported using psychological tests for both clinical and correctional purposes.

Only one state reported that it did not provide different levels of mental health services at different facilities in its DOC; that state was a small one with only one prison. Inmates in 29 states have access to mental hospitals operated by the state's division of mental health. Twenty-two states have mental-hospital-level facilities within their DOCs. Thirty-three have mental health units within some prisons, intermediate in resources between hospital-level and general population. Thirty-one use security management units for mentally disordered inmates. Thirty-six provide mental health services in outpatient clinics within facilities, and 47 offer treatment within the general population (Table 2).

Twenty-five states reported that mentally disordered offenders were placed in facilities with enriched mental health resources. Thirteen reported that such inmates were placed in management units chiefly intended to control aggressive inmates. And eight reported that maximum security facilities were used to house mentally disordered offenders (Table 3).

Thirty DOCs provide opportunities for some inmates (usually first-time offenders convicted of nonviolent crimes) to go to military-styled boot camps, completion of which usually results in immediate parole, regardless of the

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Table 1
Effects of Psychiatric Diagnosis

Question	Yes	No
1. Does psychiatric diagnosis affect initial placement?	Remaining states	MA, ME, RI
2. Does psychiatric diagnosis affect subsequent placement?	Remaining states	ME, RI, WA, WV
3. Is there a formal psychiatric classification system?	AZ, CA, CO, FL, GA, LA, NH, NV, NY, PA, TN, TX, VA	Remaining states

Table 2
Levels of Mental Health Services

	States
DMH hospital (Yes)	AL AZ CA CO CT DC DE GA HI KS KY MI MO MT NE NJ NM NY ND NV OH OR PA RI UT VA VT WI WV
DOC hospital (Yes)	AZ FL IL IA KY MA MI MN MO MS NH NM NM NC NV OK PA SC TN UT VA WV CA
Mental health unit (No)	IA ME MI MN MS ND NH NJ NM NY OK PA RI SC VT WI WV WY
Management unit (No)	DE ID IL IN ME MN MO MT ND NE NH NM NV NY RI SD TX VA WV WY
Clinics (No)	DE GA IA ME ND NJ NM NY OH PA RI SD VT WV WY
Population (No)	ME NM NY WV

Note—DMH indicates Department of Mental Health.

Table 3
Types of Facilities Receiving Mentally Disordered Inmates

	States
Enriched mental health unit (No)	AR IL MA ME MN MS NC NJ NY OK RI TN UT VA VT WY
Management units (Yes)	AK AZ CA CO IA MY NJ NM NV OH PA TX WI WV
Maximum security (Yes)	AK DC IA MO NJ TX WI WV

length of the sentence. For inmates who qualify, this is perhaps the best “deal” they can get from the DOC, which is under increasing economic pressure to transfer inmates to the community. Of

those 30 boot camp programs, however, inmates with major mental illnesses are barred from participating in 21, and those who require psychotropic medication are barred in one more (Table 4).

Table 4
States Having Boot Camp Experiences

	<u>States</u>
Boot camp available in DOC	AL AR AZ CA CO DC FL GA ID IL KY LA MA MD MI MS NC NE NH NV NY OH OK PA SC TN TX VA WI WY
MDOs cannot go to boot camp	AR AZ CO GA ID IL KY LA MA MI NC NH NV NY OH PA SC TN TX VA WI
MDOs cannot go to boot camp if they need medication	MS

Note—MDO indicates mentally disordered offender.

Discussion

It appears from the results of the survey that the difficulties experienced by mentally disordered inmates in the two systems presented initially are common throughout correctional systems. Psychiatric diagnosis *per se* affects initial placement in 48 jurisdictions and subsequent placement in 47. Mentally disordered offenders may find themselves in management units or in maximum-security facilities because of their disorders (or the treatment required to control their disorders) in 20 states. They are often denied placement in less restrictive facilities because of their disorders, even if their crimes and subsequent behavior would otherwise justify such placement. And they are denied the opportunity to take years off their incarceration times in 22 of the 30 states that offer boot camp experiences.

Why does such discrimination occur? Is it solely because of the stigma and associated myths attached to the status of mental disorder as used to be the case in most of society? Although some such residual effects certainly exist in correctional systems, especially at the interper-

sonal level with some correctional officers and other inmates (just as it continues in society at large), it would appear that the major reasons for formal rules establishing discrimination based on status these days are a combination of dwindling economic resources and increased legal scrutiny. Correctional systems continue to be growth industries in most states, as the public demand for protection mirrors the rise in violent crime rates. But while this political pressure has been translated into the doubling of prison populations over the last decade,¹⁴ the economic recession has prevented states from increasing rehabilitative resources (including mental health staffing and facilities) at the same pace. With the increasing proportion of inmates who suffer from severe mental disorders, the end result is a decrease in the mental health resources available per inmate.

During the same time period, the correctional systems in half the states have been the targets of litigation seeking to establish constitutional minimum standards of living for inmates.¹⁵ While the courts have rejected many of the

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plaintiffs' requests and have adopted the high threshold of requiring demonstration of deliberate indifference (rather than negligence) on the part of correctional officials before constitutional violations can be found,¹² they have still in practice established minimum standards for the provision of health care (including mental health care), which many correctional systems were not able to meet with existing resources.

Because few legislatures were willing (or able) to fund extensive mental health programs at all facilities, most states have followed the course of specializing, providing only basic outpatient services at most facilities, and enriched units at a few, with transfer to a correctional mental health facility or a state mental hospital available for acute crisis situations. Because many mentally disordered inmates, even those whose disorders are in at least partial remission through treatment, pose management problems different from those posed by other inmates, it has seemed logical for correctional administrators to concentrate the limited mental health services available in the more secure facilities.

Inmates whose disorders do not cause behavioral problems that would preclude placement in minimum security facilities still require regular medical monitoring for the effects and side effects of their medication, and staffing with trained mental health nurses is not possible at all facilities. So, paradoxically, successful efforts to provide minimally adequate mental health resources for all inmates has resulted in transfer limitations for many of them.

We are arguing here only against *per se* restrictions based on the status of having a psychiatric diagnosis or requiring psychotropic medications to maintain acceptable behavior. It is clear that some inmates' disorder-related behavior legitimately prevents them from meeting standards for less restrictive environments and that transferring them to such environments may well result in clinical deterioration. In particular, the significant emotional and physical stress associated with boot camps can be expected to overwhelm many seriously mentally ill inmates.

The problems of *per se* restrictions are not fixed in concrete, however. Despite the notorious resistance of bureaucracies (especially correctional ones, which are not primarily established to provide humanitarian services to their clients), clinicians in correctional systems can serve as effective advocates for their patients. For example, efforts by organized clinicians in System B have resulted in new programs in one area with a number of facilities (including some minimum security ones) to provide sufficient monitoring of medications to permit appropriate inmates to be placed in minimum security facilities that were previously barred to them.

Because such changes almost always require system-wide planning and allocation of resources, it is crucial that mental health services be centralized throughout the system under a clinical administrator. Clinicians at autonomous facilities are at the mercies of individual wardens and of the correctional administrators who make transfer deci-

sions. Without a unified voice in the central administration of the DOC, such changes are often impossible to effect.

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