

# A Typology of Patients Admitted to a Forensic Psychiatric Hospital from Correctional Settings

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**A typology of inmates and pretrial detainees admitted to a secure forensic psychiatric hospital was developed using the referral or adjustment problem at the correctional setting as the classifying variable. An eight-group typology was derived along with a description of each type's demographic, criminal, psychiatric, and institutional characteristics. Although the typology appears to be centered primarily on the characteristics of the inmate, closer examination reveals that the resulting schema is more accurately a description of the types of problems presented by the inmate within the correctional setting. From this perspective, the typology is a classification of referral problems that likely says as much about the referring institution as it does about the subject of the referral. Each group within the typology is based on an interaction representing a "poor fit" between the inmate and the institution. Each type of patient problem is described, and various solutions aimed toward improving the fit between the inmate and the setting are discussed.**

As the rate of incarceration in the United States continues to soar, the number of inmates and pretrial detainees in need of mental health services has proportionally risen. The net effect of overcrowded institutions, lengthier sentences, less "good time" credits, higher standards for parole and early release, and decreases in recreational and rehabilitation programming

has produced a greater demand for mental health services for a larger proportion of prisoners with more varied and complicated mental health needs. The problem of an expanding number of mentally ill persons within correctional settings has been compounded by the public and private sector forces of managed care, deinstitutionalization, and welfare and social service reform, which has made mental health and social services a scarcer resource among the poor.

Research estimates of the prevalence of mental disorder within correctional populations have consistently found signifi-

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cantly higher rates of mental disorder in jails and prison than in the general population.<sup>1-3</sup> When compared with the unselected population, prisons and jails have been found to have anywhere from a four- to six-fold higher rate of mental illness. These estimated prevalence rates are staggering when viewed within the present-day context of the continuously rising rate of incarceration in the United States. The over-representation of the mentally ill within correctional settings is overburdening an already thinly stretched prison mental health delivery system.

A critical issue in the new penology is to determine how mentally ill inmates, compared with non-mentally ill inmates, adjust to the stress of prison. Studies examining the institutional adjustment of mentally disordered offenders report that they generally have a more complicated adaptation to the prison milieu as measured by rule violations and incidents of misconduct.<sup>4-7</sup> Mentally disordered offenders may be especially vulnerable to abuse by other offenders and may find themselves in greater need of protective segregation or isolation. They may also tend to accumulate disciplinary sanctions resulting from their disruptive behavior, which causes them to be placed in higher security settings, limiting their access to privileges, programs, work release assignments, and early parole.

DiCataldo *et al.*<sup>8</sup> found that inmates in a maximum security prison who endorsed positive symptoms of schizophrenia on a mental health screening measure had significantly more incident reports filed about them during their first 90 days after admission than those inmates who did not

endorse similar symptoms. This study's identification of behavior problems arising early in the mentally ill inmates incarceration history forcefully points to the need to identify mentally ill inmates early. Early identification will help circumvent the accumulation of incident reports by mentally ill inmates. Their behavioral record is often used in decisions about movement to less restrictive settings and early release. Treating their mental illness early should help assure that they are not unduly penalized because of their mental illness.

Mentally ill inmates pose special problems within correctional settings. They are not equipped with the same level of abilities and capacities to adapt and negotiate their way through the complicated and often dangerous social networks within the prison environment. They are easy targets for abuse, may have trouble following prison rules, and generally have a lower threshold for stress and isolation. In short, they are less able to cope with the inherent challenges and stresses that go along with serving time. The placement of a critical number of mentally ill inmates within a correctional facility could severely hamper the smooth and safe operation of a prison.

The early and prompt identification of the mentally ill among the rising population of prison inmates is not only an effective prison management strategy; it has become a legal requirement. The U.S. Supreme Court, beginning with *Estelle v. Gamble* in 1976,<sup>9</sup> formally recognized a prisoner's constitutional right to treatment by establishing minimum standards of medical and mental health care within

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correctional facilities. Later, in *Ruiz v. Estelle* (1980),<sup>10</sup> the Court established basic minimum constitutional requirements for a mental health treatment program. Among the standards derived from this case was the requirement that the prison systematically screen and evaluate inmates to identify the mentally disordered who are in need of mental health treatment.

There presently exists a variety of standards for correctional health care set forth by national organizations seeking to set the minimum level of mental health care required within correctional institutions. The National Commission on Correctional Health Care,<sup>11</sup> for example, requires that all inmates receive a mental health screening evaluation by a qualified health care professional upon their admission to the facility. A recent survey of state departments of correction by Metzner and colleagues<sup>12</sup> found that nearly every state correctional system provided some form of admission mental health screening evaluation to all newly committed inmates.

The effective screening of inmates within the prison system has been a difficult task that has not been approached uniformly across states. There is no standard method used to screen for mental illness among prison inmates reported in the field or the clinical literature.

Although research attempts at developing a mental health screening instrument designed from general clinical instruments for correctional settings have not yielded practical results, there have been advances in the area of defining and categorizing the distinctive problems posed by mentally ill offenders in correctional

settings. A variety of typologies or classification systems for adult inmates have appeared in the correctional and mental health literature. The most widely used and cited system was developed by Herbert Quay, who termed his schema the Adult Inmate Management System (AIMS). The AIMS was developed by Quay for the U.S. Federal Bureau of Prisons to assist in the classification of adult male offenders.<sup>13</sup> The system requires that correctional officers rate the behavior of inmates on their unit. The ratings are then used to assign inmates to one of the following categories: Aggressive-Psychopathic, inmates who are hostile, violent, and anti-authority; Manipulative, inmates who engage in covert violations of institutional rules and regulations; Situational, inmates who exercise good behavioral control and infrequently engage in violence or disciplinary problems; Inadequate-Dependent, inmates who are socially withdrawn, immature, and prone to victimization by others; and Neurotic-Anxious, inmates who are chronically distressed. The latter two categories within Quay's system would likely contain the highest concentration of mentally ill offenders.

Rice and Harris<sup>14</sup> also developed a five-category system of classification for adult inmates based on the inmates' clinical presentations at the time of their admission. They broke out their subgroups into the following system: (1) relatively low risk offenders who exhibit few behavior problems in prison; (2) high risk offenders who exhibit few behavior problems in prison; (3) high risk offenders who present significant management

problems in prisons; (4) inmates of varying levels of risk who exhibit psychotic symptoms and social withdrawal while in prison; and (5) a small group of inmates with serious mental disturbances who exhibit active psychotic symptoms, social withdrawal, and severe management problems while in prison.

This system's last two groups match closely with the Toch<sup>15</sup> and Toch and Adams<sup>7</sup> descriptions of the Disturbed-Nondisruptive inmate and the Disturbed-Disruptive inmate. It is the members of these groups who will most likely need the assistance of mental health services within a jail or a prison.

This article presents the results of a project that developed a typology of prison inmates and pretrial detainees admitted to a forensic psychiatric hospital for evaluation and treatment. The subjects who comprise this study sample represent some of the most difficult to manage and high risk men in the correctional system. The assessment task can typically be distilled down to a basic clinical decision: either commit the patient to a hospital setting faced with limited resources that must be judiciously disbursed, or return the patient to the correctional facility that referred him to cope in the highly stressful setting of the jail or prison.

The approach here is to systematically review the types of referral problems presented by these patients and their institutions. The classification of referral problems, which often says as much about the referring institution as it does about the subject of the referral, will serve as the categorizing variable in the formation of this typology. Although this typol-

ogy will refer to a type of patient, it more accurately reflects a type of problem presented by the patient within the context of the correctional setting. From this perspective, the typology is based on an interaction and is more like a nosological system of "poor fit" between the inmate and the correctional setting. A more systematic understanding of the referral problems presented by these patients will hopefully allow for better, more informed decision-making by the clinicians who evaluate them.

## Methods

*Subjects* The sample for this study was drawn from male patients admitted from a jail or a prison to a secure forensic psychiatric hospital for an evaluation of their need for further care and treatment in a hospital setting. Patients were admitted to the forensic hospital from a jail or a prison after an examination by a psychiatrist or psychologist at the correctional setting concluded that the inmate or pretrial detainee was mentally ill and posed a substantial risk of harm to himself or others. The referring psychiatrist or psychologist recorded the findings of the examination in a brief paragraph on a court petition form. The completed petition with the clinical conclusions regarding the inmate's or pretrial detainee's need for psychiatric hospitalization in a secure setting is reviewed and then authorized by a district court judge. By statute the subject of the petition is represented by counsel. In some rare instances, the referring psychiatrist or psychologist is required to provide testimony, usually only when the patient wishes to contest

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his transfer from a correctional setting to a hospital setting.

The length of hospitalization is for a period of up to 30 days. At the time of admission, the patient would receive an evaluation from a forensic psychiatrist or psychologist who interviews him, reviews relevant records and reports, and consults with the patient's treatment team. According to applicable statutes, the forensic psychiatrist or psychologist is required to prepare a written report about the findings of the examination. The report shall contain an opinion about the patient's current state of mental health and whether the patient met the legal standards of commitment to the hospital, which required that the patient pose a substantial risk of harm to self or others by reason of mental illness.

The study examined a total of 150 patient admissions to the forensic hospital between 1990 and 1996. The mean age of the sample was 31.5 years. White subjects comprised about 60.7 percent of the sample, whereas African-American, Hispanic-Latino, and Asian subjects comprised 22.7 percent, 14.0 percent, and 2.6 percent, respectively. Approximately 57.3 percent of the sample was referred from a jail, and about 42.7 percent came from a prison. The sample was nearly evenly distributed in terms of their legal status, with 53.3 percent serving time and 46.7 percent awaiting trial. Two-thirds (67%) of the subjects were awaiting trial or serving time for a crime against a person, and one-third (33%) were charged with or had been convicted of a crime against property.

Each patient received a forensic examination regarding his current state of men-

tal health and whether he was currently mentally ill and posed a substantial risk to harm self or others. The findings of the examination were contained in a court-ordered evaluation report, which served as the database for this study. The variables of interest were obtained from the contents of these reports that contained demographic information, background data, legal history, psychiatric history, information about the hospital course, and current mental status data. The entire sample averaged about three admissions per subject, but this mean was artificially inflated by a small subgroup of patients who had a very high rate of admission. A total of about 41.3 percent were diagnosed with an Axis I mental disorder, and the remaining 58.7 percent received an Axis II diagnosis or no diagnosis. About 16 percent of the sample reportedly had engaged in a violent incident or received an incident report for a threat of violence while at the hospital. A total of 28.0 percent of the sample were found to have met the legal criteria for involuntary commitment because they were mentally ill and posed a substantial risk of harm to themselves or others. These patients were subjected to a commitment hearing in court where they could be committed for up to six months in the forensic hospital before they being returned to the sending institution. The remaining 72 percent of the sample was returned to the referring correctional facility prior to or at the end of the 30-day initial observation period. Table 1 contains a summary of the demographic, crime, and clinical variables of the sample subjects.

**Procedure** A sample of 150 evalua-

**Table 1**  
**Demographic, Criminal, and Clinical**  
**Characteristics**

Age (mean)	31.5 years
Average number of admissions	3.0
Race	
Caucasian	60.7%
African-American	22.0%
Hispanic	14.0%
Other	2.6%
Type of institution	
Jail	57.3%
Prison	42.7%
Legal status	
Serving time	53.3%
Awaiting trial	46.7%
Type of offense	
Person	67.0%
Property	33.0%
Had a violent incident in jail/prison	16.0%
Diagnosis	
Axis I	41.3%
No Axis I	58.7%
Outcome of evaluation	
Committed to hospital	28%
Returned to jail/prison	72%

tion reports was selected from a larger sample of some nearly 400 reports prepared between 1990 and 1996. A preliminary review of a large sample of cases was conducted by the author and a 15-group schema of referral problems or types was developed. A research assistant provided with a copy of the patient's evaluation report and a description of the 15-group schema assigned each case to the type that most closely matched the case. After all of the cases were classified, infrequently found types were eliminated from the classification system. Types that were conceptually close to each other, as demonstrated by a frequent number of cases with the ability to be classified in both types, were combined

resulting in an expansion of the definitional boundaries of the newly formed category.

The research assistant recorded data from the report on a form that included demographic, criminal, and clinical information about the patient. The most important variable recorded from the report was the reason for admission, which served as the grouping variable. The presenting problem that resulted in the patient being transferred from a correctional setting to a psychiatric setting determined which group or type category the patient was placed in. After the research assistant initially classified each of the subjects into 1 of the 15 types, the author reviewed each of the cases for inter-rater agreement. The overall agreement between the two raters was more than 90 percent. The classification decision of the author was used on cases in which there was disagreement.

## Results

The results yielded an eight-group typology, which was able to capture a total of 94.7 percent of the entire sample. A summary of each of the types is found in the "Appendix."

The first type was labeled the Psychotic-Disruptive Offender. The patients within this group exhibit acute symptoms of a psychosis, which interferes with their ability to reside in a correctional setting. The patient may have a chronic psychotic disorder and may experience acute exacerbations that require periodic hospitalizations for stabilization before he is returned to jail or prison; or the patient may be experiencing his first and only psy-

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chotic episode brought on by the stress of his arrest, arraignment, and incarceration. This was the largest group, capturing a total of 27.3 percent of the sample. They had a higher rate of admission (3.8) and were more likely than most of the other types to be committed to the hospital (41.4%).

Type two was called the Malingering-Instrumental Offender. These patients report psychiatric symptoms, threaten self-harm, or engage in self-harm to be moved from a correctional setting to a clinical setting, which they perceive as more comfortable or more advantageous to their pending legal case. Patients concerned about their safety because of institutional problems, such as a gambling debt or being identified as having cooperated with an administrative investigation, are also included in this group. This was the second largest group, comprising a total of about 20.7 percent of the sample. They tended to be younger, with an average age of 25.2 years, and were generally assessed as feigning the symptoms of mental disorder. They were rarely committed to the hospital.

The third grouping was the Depressed-Suicidal Offender. These patients experience an acute depression, often precipitated by the loss of an important personal relationship or the occurrence of an anniversary date. This type includes those patients who become depressed after receiving sentences to a lengthy prison term. These patients were more likely to be admitted from a prison than most of the other groups. They had a high rate of person offenses (78%) but a low rate of violent incidents while at the hospital

(5.0%). They comprised 17.5 percent of the entire sample.

The fourth group were referred to as Anxious-Distressed Offenders. These patients, typically young and new to a correctional setting, presented as distressed, anxious, and dysphoric. They often expressed fear about being victimized by other inmates. They had a mean age of 25.2 years. About 94 percent of them were admitted from jails, and 76.5 percent were awaiting trial. They also had a higher proportion of nonviolent charges (41.2%). Approximately 35.3 percent were diagnosed with mood or adjustment disorders, and about 29.4 percent of them were committed to the hospital. This type comprised a total of 11.3 percent of the sample.

The Violent-Exploitative Offenders comprised the fifth group. Patients within this group were apt to have a history of institutional violence, which often landed them in administrative segregation. They often engaged in suicidal gestures or reported psychiatric symptoms to be moved from these setting or had experienced a psychological breakdown as a result of prolonged exposure to these settings. This group comprised about 8.6 percent of the sample. They were the most violent of the types, with a total of 31 percent of them engaging in a violent incident or the threat of a violent incident while at the hospital. They were young, with an average age of 24.8 years, and were always returned to the sending institutions.

The Self-Abusive-Disruptive Offenders made up the sixth group. These patients typically suffer from a severe personality disorder and have major coping

deficits. They engage in an often intractable and unremitting pattern of self-injury (i.e., self-cutting or insertion) as a means of releasing tension, discharging anger, controlling their environment, inducing negative affective states in the staff, or forestalling a more pervasive decompensation in their psychological functioning (i.e., depersonalization or derealization). This group totaled 8.0 percent of the sample. They were overwhelmingly white (83.3%), were sent from prisons (58%), and had the highest average of admissions, with a mean admission rate of 6.0. They had the highest rate of violence or threat of violence of any of the groups (25.0%) but had a low rate of person offenses as their committing offense (50%). A total of about 8.0 percent of this group was assessed as exhibiting frank psychotic symptoms. They clearly are the most difficult to manage patient in the correctional system and absorb a tremendous amount of staff resources, both physically and psychologically.

The seventh type was labeled the Hostile-Protesting Offender. These patients have an identifiable grievance against the correctional institution or the court system and engage in self-harming behavior (i.e., hunger strikes) as a means of drawing attention to their issues. They are a small group, comprising a total of 3.3 percent of the sample. They are older than the general inmate population, with a mean age of 42 years, are more likely to have been admitted from a prison than most of the other groups (60%), and have a higher than usual rate of admission (4.4%). They are not a threatening or aggressive group. None of the cases in

this sample received incident reports for threats or violent behavior. Finally, they were not typically assessed as mentally ill, and none of them were committed to the hospital.

The eighth type was called the Fixated-Delusional Offender. These patients typically are admitted from a prison, where they have served a long sentence. They are quietly psychotic, but their psychosis does not generally interfere with their ability to function in a correctional setting. They are often close to the scheduled completion of their sentences, and their psychotic symptoms, which usually involve a dangerous delusion about a targeted person, raise grave clinical concerns about their safety in the community. The occurrence of this type is rare, comprising only 3.3 percent of the sample. They are mostly white (80%), usually sent from prison (80%), and are serving time for a crime of violence. Four of five of these patients were diagnosed as suffering from delusional disorders, ranging from erotomanic delusions about a female media star to paranoid delusions about the members of a police department (whom the inmate had attempted to shoot to death 10 years earlier). Their delusions often remain untouched and well preserved despite many years of physical separation from their target by way of incarceration. All of the members of this category were committed to the hospital for further treatment.

## Discussion

National correctional health care organizations and the courts, including the U.S. Supreme Court, have set forth guide-



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lines requiring that prison facilities routinely screen inmate populations to identify the mentally ill so that they may be provided effective treatment or safe transfer to appropriate clinical settings. Although almost all states have complied with this general guideline, there is as of yet no firmly established means of screening for mental illness among prison inmates that is used in the field or reported in the literature. The development of a screening measure specifically designed for use within a jail has not yielded encouraging results in subsequent research.

Another promising approach to the problem of identifying the mentally ill inmate has focused less on issues of psychiatric diagnosis and has sought to define the problem at the interface of the troubled inmate and the institution. The development of a typology of problems presented by mentally ill or disruptive inmates looks at the issue as an interaction between the characteristics of the institution and the personality dynamics or psychiatric symptoms of the inmate. The advantage of this approach is that solutions are sought beyond merely diagnosing the inmate as mentally ill or not or as being in need of mental health treatment or not. Instead, the problem becomes the focus, and interventions can include shifts in the environmental contingencies that drive the problematic behavior. The disadvantage of this approach is that it is not employed until a problem arises, instead of identifying the problem before it erupts.

In this study, an eight-group typology of patients admitted to a secure forensic

hospital from the state prison system or county correctional facilities was generated from a review of various records of 150 hospital admissions from these settings. The types include 1) the Psychotic-Disruptive Offender, 2) the Malingering-Instrumental Offender, 3) the Depressed-Suicidal Offender, 4) the Anxious-Distressed Offender, 5) the Violent-Exploitative Offender, 6) the Self-Abusive-Disruptive Offender, 7) the Hostile-Protesting Offender, and 8) the Fixated-Delusional Offender.

Each type within the classification system represents a unique referral problem based on the presence of poor adjustment within a correctional setting. The members of each of these groups exhibited some form of crisis management problem within the prison and jail, which was dealt with by transferring them to a secure forensic psychiatric hospital. A review of the defining characteristics of each of the types clearly indicates that many of them do not suffer from mental disorders that require psychiatric treatment in a secure inpatient setting. Only a total of about 28 percent of the entire sample were committed to the hospital for further care and treatment. Most of these commitments were extended to patients diagnosed with a psychotic or severe mood disorder. The remaining three-quarters of the admissions were returned to the correctional setting.

The system developed in this study has some conceptual overlap with other typology of prison inmates reported in the literature. The AIMS, developed by Quay,<sup>13</sup> has groups within it that are very much like those in the system reported

here. For instance, his Aggressive-Psychopathic group is similar to this system's Violent-Exploitative type. Both groups contain inmates who have a history of severe antisocial and violent behavior in the community and who continue to display these problems within the controlled setting of the prison. Quay's Manipulative group shares important similarities with this study's Malingering-Instrumental group. Both groups work on a covert level to obtain self-serving ends, often engaging in deception and fakery to achieve these ends. Quay does not have a type that specifically identifies psychotic inmates, but his Inadequate-Dependent category, which contains withdrawn inmates prone to victimization, would likely capture the members of the Psychotic-Disruptive group. This category bears a striking similarity to the Toch<sup>15</sup> and the Toch and Adams<sup>7</sup> Disturbed-Disruptive group, which in turn shares conceptual overlap with the Fixated-Delusional type from the present study. Both groups contain quietly mentally ill inmates who are likely to escape the detection of the correctional and mental health staff. Finally, the current study's Depressed-Suicidal type would likely capture the same members as Quay's Neurotic-Dependent group.

The real practical value of this typology comes from seeing each of the groups as a type of problem that needs to be solved rather than simply viewing the inmate as a pathological entity that needs to be diagnosed and treated to adapt to the institutional setting. Each type is an instance of poor person-environment interaction. Problem-solving should focus on

diagnosing the problem and not just on the patient/inmate. Solutions must be aimed toward the resolution of the problem and correcting the poor fit between the inmate/patient and the correctional setting. This orientation toward problem-solving should, in all likelihood, decrease the rate of inappropriate referral to the forensic hospital and lower the overall level of stress and tension within the correctional setting that is often generated by and around these patient/inmates.

It is important to resist the almost automatic tendency to view each of the types as representing a particular form of psychopathology existing within the inmate. Alternatively, viewing each type as a dynamic interaction between the inmate and the institution presents a more developed understanding of the nature of the problem. The clinical evaluation of these patients should seek not only to obtain diagnostic information about their symptomatology and personality functioning but also to understand how these abilities and capacities interact with the environmental demands of the prison setting.

Different strategies will undoubtedly be needed with different groups. For instance, some groups, such as the Psychotic-Disruptive, the Depressed-Suicidal, and the Fixated-Delusional, will require transfer to a secure psychiatric hospital and may even be in need of protracted lengths of inpatient care. Once returned to a correctional setting, these inmates will likely need continued mental health monitoring and treatment to remain in these high stress settings. Other groups, such as the Anxious-Distressed, the Self-Abusive-Disruptive and the Hostile-Protest-

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ing inmates, would likely benefit from more intensive mental health services offered within the correctional setting. It may be best in the long run to prevent the transfer of these inmates, if the risk of harm to self or others is not too high. This strategy bypasses the reinforcing aspects of being transferred out of the highly stressful setting of a prison into the more comfortable confines of a hospital.

The Self-Abusive-Disruptive inmate is likely to respond best to a behavioral management program that controls the contingencies of reinforcement. A program for these inmates will require flexibility and cooperation on the part of the administration of the correctional institution to stabilize these inmates. They often generate a tremendous amount of institutional expense for late night trips to local emergency rooms to repair the damage they have done to themselves and often demand time and energy from many different staff members. The negative attention they garner and the expenses they amass often reinforce aspects of their behavior, helping them maintain their grandiose view of themselves. Such behavior serves as a means to express their intense hostility toward others. The Anxious-Depressed and the Hostile-Protesting groups would also likely benefit from mental health services offered within the correctional facility, which could aid in their adjustment to institutional life.

The Malingering-Instrumental and the Violent-Exploitative groups are less in need of mental health services and need to be dealt with directly by the correctional institution. The early identification of these inmates by the mental health

system can prevent the necessary and often reinforcing transfer of these inmates to hospitals, where they often exert a very disruptive effect on the therapeutic milieu, interfering with the treatment of patients who are truly in need of inpatient care. Providing consultation to prison staff on how to understand and manage the attention-seeking and self-serving aspects of these inmates' behavior can help prevent their movement from the correctional setting to the hospital setting, thus avoiding the unnecessary drain on clinical resources.

## Conclusion

The typology presented in this study was based on a small sample and needs to be cross-validated with a larger sample. The system also needs to be independently cross-validated within another setting to determine whether the types have any viability outside the unique characteristics of the sample in which this study was conducted. Further, interventions designed specifically for each of the types needs to be developed, and then the effectiveness of those interventions must be measured through an assessment of their differential impact on the admission rate to the hospital.

More research is needed to broaden our understanding of the mentally ill within prison settings. Research must target such areas as developing a more complete understanding of what functional capacities and abilities are needed to serve time productively and who among the legion of the mentally ill within prison possess or lack these skills. Furthermore, research

must begin to investigate whether inmates who lack these capacities can acquire them through treatment. Clearly, a more effective screening measure is needed as well, along with a more refined classification of the types of problems that mentally ill inmates present within prison. Finally, further research is necessary to look at ways to alter prison policies and procedures to accommodate the deficiencies of the mentally ill, who may not be able to adhere to the same level of regulation that non-mentally ill inmates are capable of achieving.

#### Appendix: Clinical Description of Each of the Offender Types

1. *Psychotic-Disruptive Offender*: Inmates manifest acute symptoms of a psychosis that interferes with their abilities to reside in a correctional setting. The patient may have a chronic psychotic disorder and experience acute exacerbation, which requires periodic hospitalizations for stabilization before he is returned to jail or prison. Or the patient may be experiencing his first and only psychotic episode, brought on by the stress of arrest, arraignment, and incarceration.

2. *Malingering-Instrumental Offender*: Inmates report psychiatric symptoms, threaten self-harm, or engage in self-harm in order to be moved from a correctional setting to a clinical setting, which they perceive as more comfortable or more advantageous to their pending legal cases. Patients who are concerned about safety because of institutional problems such as a gambling debt or being identified as having cooperated with an administrative investigation are also included in this group.

3. *Depressed-Suicidal Offender*: These inmates experience an acute depression often precipitated by the loss of an important personal relationship or an upcoming anniversary date. This type includes those patients who become depressed after receiving sentences of a lengthy prison term.

4. *Anxious-Distressed Offender*: These inmates are typically young and new to a correctional setting and present as distressed, anxious, and

dysphoric. They often express fear about being victimized by other inmates.

5. *Violent-Exploitative Offender*: Inmates within this type often have a history of institutional violence that has landed them in administratively segregated settings. They often engage in suicidal gestures or report psychiatric symptoms in order to be moved from these settings, or they experience a psychological breakdown as a result of prolonged exposure to these settings.

6. *Self-Abusive-Disruptive Offender*: These inmates typically suffer from a severe personality disorder with major coping deficits. They engage in an often intractable and unremitting pattern of self-injury (i.e., self-cutting or insertion) as a means of releasing tension, discharging anger, controlling their environment, inducing negative affective states in the staff, or forestalling a more pervasive decompensation in their psychological functioning (i.e., depersonalization or derealization).

7. *Hostile-Prototyping Offender*: These inmates have an identifiable grievance against the correctional institution or the court system and engage in self-harming behavior (i.e., hunger strikes) as a means of drawing attention to their issues.

8. *Fixated-Delusional Offender*: These inmates typically are admitted from a prison where they have served a long sentence. They are quietly psychotic, but their psychoses do not generally interfere with their ability to function in a correctional setting. They are often close to the scheduled completion of their sentences, and their psychotic symptoms, which usually involve a dangerous delusion about a targeted person, raise grave clinical concerns about their safety in the community.

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