MENTALLY DISABLED PRISONERS PLANNING RESOURCES

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THE TERM ‘MENTALLY DISABLED’ IS DELIBERATELY USED IN THIS PAPER TO encompass psychiatrically disordered, intellectually disabled (ID) and dually diagnosed offenders. Offenders who display maladaptive behaviours are seriously limited in their opportunities for integration into educational, residential, employment and recreational facilities both inside and outside prison.

It is usually the presence of antisocial maladaptive behaviours which is a major deciding factor in imprisonment for either psychiatrically ill or ID offenders. It is indisputable that another major deciding factor is the absence of appropriate alternative sentencing resources. Judges are concerned about imprisoning offenders with an obvious mental disability, particularly as they are likely to be placed on protection in the gaols and yet still be a target for victimisation by other prisoners. Furthermore, the likelihood of receiving in protection any relevant programs which would enhance an independent, non-offending lifestyle is remote. Lawyers, care-givers, and expert witnesses are all aware of the dreadful disadvantages of imprisonment for mentally disabled offenders.

The problem begins well before the ultimate sanction of imprisonment occurs. Numerous studies over 40 years have documented the fact that problem behaviours and antisocial acts are, next to severity of ID, the most significant factor in influencing initial placement in an institution and decisions for re-institutionalisation (Bruininks et al. 1988). Various studies have found between 20 and 45 per cent of ID clients have limited community participation, particularly community living, owing to behaviour problems. It appears that 20 to 40 per cent of ID people in various samples and service programs exhibit serious problem behaviours, and between 5 and 13 per cent have the dual diagnosis of mental illness (Bruininks et al. 1988).

The significant issue for correctional services is, if such people cannot live in the community because of problem behaviours, where can they live? The option of institutionalisation becomes remote as institutions either close down, reduce client numbers or change their functions. Whilst there is no suggestion that institutions should be re-opened...
to cater for the dually diagnosed client, the reality is that there are few residential facilities with the resources to cope with problem behaviours. The baby has been thrown out with the bath water and has gone down the plughole that leads to imprisonment.

The aim of this paper is to describe a model of service delivery for mentally disabled offenders which will enable non-custodial sentencing options to be utilised effectively for the benefit of the offender and the community.

The Current System

There are a number of drawbacks to the present system of addressing the problem of mentally disabled prisoners. First, there is the feeling by convicted persons that the process leading up to trial is so punishing that they feel that they have then discharged their obligations and 'made up for' the crime.

Second, probation and parole services are generally overstretched. Professionals have large case loads and lack the training to identify and assist mentally disabled offenders (White & Wood 1988). Specialist services are frequently unwilling to accept responsibility for those of their clients who commit crimes and, furthermore, are untrained in criminal justice issues—they may even do their client more harm than good in the court.

Courtroom personnel at all levels are unfamiliar with all but the broadest issues regarding mental disability. The expectation of the criminal courts that they are dealing with 'the dregs of humanity' predisposes a situation where no-one is surprised that an accused is illiterate, or unable to communicate competently in the verbal arena. When these phenomena are uncritically accepted as 'normal', it is highly unlikely that the accused will be referred for expert assessment.

The expert assessment may be inappropriate or unhelpful. A psychiatric examination may shed little light on the offender's deficits in intellectual, social and adaptive skills. A report by a physician or general practitioner is likely to be even more general. Comprehensive multidisciplinary assessment is the exception rather than the norm.

The final and most pervasive obstacle, however, remains the dearth of appropriate services—residential, educational, vocational, interpersonal relationships and adaptive skills programs—which will admit a mentally disabled offender, particularly one who is regarded as violent or dangerous. Inexorably, the wheel turns back to the realisation that prison is the one residential service which cannot abrogate responsibility.

Model Service Provision for Mentally Disabled Offenders

Identification

There is no service program which will ensure that an offender's mental disability will be recognised by police, lawyers, judges, parole officers, health professionals not expert with mental disability, or other involved parties. It is not unusual for an accused to be unaware that he or she has a mental disability—or when they know they have a mental disability, they may do their utmost to conceal it, to appear normal.

Training for awareness of mental disability is an important and fruitful step. No-one has ever been disadvantaged by undergoing full assessment and being found not to have a problem, but the reverse situation is not so benign in its consequences.

Criminal justice personnel can be educated to enquire about likely indicators of mental disability, including questions concerning school history, numbers of schools attended, special school or class placement, truancy. The usual pattern of assumed causality needs to be set aside—an offender is often assumed to be illiterate owing to a fragmented school
history. Too often the fragmented school history reflects an inability to cope in the education mainstream and desperate attempts by parents or teachers to find a suitable placement, or equally desperate attempts to dump the individual in someone else's 'too hard' basket. Slow speech, poor memory, poor sequencing of events, childhood history of institutional placement, and psychiatric hospitalisation are all factors to which criminal justice personnel can be alerted as potential indicators. There is certainly an educational effect. For example, when lawyers recognise the presence of mental disability in a client and seek expert assessment, they become much more likely to refer subsequent clients.

**Comprehensive expert assessment**

In a straightforward case of ID, a comprehensive psychological assessment of cognitive, social and adaptive skills deficits will suffice. Other valuable input, particularly for dually diagnosed offenders, will be provided from psychiatric, medical, vocational, educational, personal relationships, physical therapy, and financial management assessments.

**Case management**

Mentally disabled offenders too readily fall between the gaps in educational, health, intellectual disability, psychiatric, probation and parole, and vocational rehabilitation services. The solution is a team approach incorporating representatives from all services, one of whom is appointed as case manager.

Locating the team physically together is significant in ensuring communication. Because of the complex and demanding nature of the cases, a smaller than usual caseload is desirable (White & Wood 1988).

**Probation**

Mentally disabled offenders can easily be placed in a 'no win, back to gaol' situation through the demands of probation or parole conditions which they cannot meet. The simplest tasks—catching public transport to the probation and parole office, using a telephone to make appointments, telling the time, knowing the date, paying fares, negotiating time away from work or sheltered workshop, responding to long term goals, attending Alcoholics Anonymous programs, enrolling in a suitable educational course, keeping away from negative peer group influences—may prove insurmountable barriers for the mentally disabled offender. Once having breached the conditions, the severity of sentencing escalates.

It is essential that an assessment be undertaken of the offender's daily living skills and abilities to meet the conditions, and appropriate support services (such as travel training) be provided.

**Reinforcing non-offending behaviour**

The attention received, albeit negative, and the lure of the illegal activity itself are strong reinforcers. Somewhat less reinforcing are monotonous, time-consuming and brief visits to an off-hand and possibly unhelpful service.

The Lancaster County (Pennsylvania) mentally retarded offenders [sic] program builds in strong positive reinforcement for compliance with community-based sentences, which includes time off reporting when improvements in social and adaptive skills are achieved (White & Wood 1988).
The regional secure unit

The 1975 Butler Report in the United Kingdom (Home Office and DHSS 1975) recommended secure hospital units for mentally abnormal offenders, and the establishment of joint forensic psychiatric services between regional health authorities and prison medical services. This idea, or a version of it, has been used in a number of places including New Zealand (Barrington 1982) and Canada (Arboleda-Florez 1981).

A regional secure unit is usually run by health services rather than correctional services and, therefore, custodial officers are not employed. Violent and dangerous patients are dealt with by medical and nursing staff. The medical model tends to prevail. The patients may be on remand, or sentenced, or non-offenders. Important questions of human rights revolve around the mechanisms for admission, review, release, and transfer back to the prison system (Spry & Craft 1984; Hayes & Hayes 1984).

The major ethical problem with existing regional secure units for ID offenders is that the medical—specifically the psychiatric model—is an inappropriate treatment and containment environment. If ID or dually diagnosed offenders are to be kept out of prison, there must be regional secure units with specialist staff (not necessarily medical or nursing staff) trained in the area of ID, and offering appropriate rehabilitation programs in the areas of daily living skills, communication, interpersonal relationships, sexuality, financial management, vocational training, coping skills, and drug and alcohol addiction. The idea is not new. The Richmond Report (1985) states:

For persons with a developmental disability who manifest severe and seemingly intractable behavioural disturbance which is unresponsive to in situ intervention, specialist behaviour management services will be available on a cross-regional basis in small, special purpose units (p. 19).

In 1988, a proposal for such a unit in NSW was put forward by staff of a centre for ID clients. The proposal stated that the reasons for the lack of service delivery to this group were:

(i) the cross-over of separate departmental responsibilities;
(ii) the inter-departmental fragmentation and protectiveness of service-delivery agencies;
(iii) the complexity and isolation of expertise from direct care providers and the lack of access to such expertise; and
(iv) as a minority sub-group (intellectually disabled offenders and behavioural 'problems') the direction of service delivery has been to care for rather than treatment [sic] (Jones et al. 1988, p. 2).

As far as can be determined, no action on this proposal has been taken. An important feature of a regional secure unit for ID or dually diagnosed offenders is the establishment of staged levels of supervision; from intensive supervision through to unsupported living and the opportunity for eventual integration into the community.

The correctional continuum

Regional secure units serve the dual goals of providing appropriate containment and programs for mentally disabled offenders whilst allowing the court to feel that the community is protected from violent or dangerous offenders. There is, however, still a need for appropriately staffed but less secure or restrictive environments for offenders who are not a
threat to themselves or others but who nevertheless require intensive programs, and supervision.

Any professional who has attempted to find a community residential placement and entry to appropriate programs for an offender who has been charged with arson, sexual offences, or assault will know that even if the individual is not violent or dangerous, it is virtually impossible to obtain placements in either government or non-government facilities. If probation or parole is contingent upon such conditions, by default the offender may end up in gaol.

It appears that no government department is willing to accept responsibility for providing appropriate resources for this category of offender. Bureaucrats mouth the cliches about 'people like this should not be in prison', but inevitably inertia coupled with the ever-present arguments about lack of funding mean that no action is taken.

The 'lack of funds' argument reflects the shallowness of problem-solving in dealing with mentally disabled offenders, when clearly the most expensive option is imprisonment. Prior to the abolition of the New South Wales Corrective Services Commission by the Greiner Liberal Government in 1988, the Commission established the policy of accepting responsibility for such offenders and providing appropriate resources and facilities in less restrictive but nevertheless appropriately secure and supervised community-based residential environments. Cost savings to corrective services would occur through not having to contain these offenders in a maximum security strict protection environment, and to the community in terms of having offenders returned to the open community with skills, resources and supports which may enable them to live a non-criminal life.

Some of the specific techniques which can be employed with mentally disabled offenders in the community include (Stumphauzer 1986):

- behavioural family contracts to assist families to change behaviour which contributes to offences;
- social skills training, including cooperation with probation requirements, job skills, problem solving, assertion training, resisting peer pressure, drug and alcohol counselling, and educational skills;
- behavioural contracting in probation and parole; defining the specific expected behaviours and those to be avoided, rather than generalised statements 'to be of good behaviour';
- implementing programs in schools and further education institutions;
- specialised behavioural therapies including cognitive restructuring, self-control training, aversion therapy stress and coping techniques; problem-solving; and
- occupational skills training.

**Conclusions**

Keeping mentally disabled offenders out of prison is a worthwhile aim, both in terms of cost benefits to governments (which is the most persuasive argument) and humanitarian goals for the individual and the community. The extent to which a community 'punishes' the mentally disabled for their condition while simultaneously refusing to provide resources, treatment and appropriate sentencing alternatives, reflects the degree to which any and every minority
group is alienated from the mainstream of society. By any barometer, the 'us and them' mentality is flourishing in Australia currently.

There are two key elements to preventing inappropriate imprisonment of MD offenders: the first is the existence of a humanitarian and ethical policy towards provision of appropriate sentencing alternatives; and the second is the implementation of cooperative and problem-solving approaches within and between government departments, so that programs such as the Lancaster County project (White & Wood 1988) can exist.

Short-sighted politicians and professionals act to maintain current programs of institutionalisation, the 'mental health industry', and the 'get tough' programs of . . . justice. At the same time, budgets have been cut for broader community programs which might have had long-term gains . . . What would it take to change our behaviour so that we could help [offenders] change? (Stumphauzer 1986, pp. 194-5).

References


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