PSYCHIATRIC TREATMENT OF VIOLENT OFFENDERS IN PRISON

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There is no treatment for violence as such; psychiatric treatment clearly can only be applied to those with a psychiatric illness. What constitutes a psychiatric illness is in itself a problem and the Victorian Mental Health Act 1986 does not define a mental illness. Further, violence in a person with a psychiatric illness is not necessarily a consequence of that illness and, conversely, all violence is not necessarily a consequence of mental illness. Psychiatrists, therefore, must be concerned with the aetiology of violence in the individual so that they may attend to that which is within their province. The aetiology of violence is a complex matter and is further confounded by terminology (Mackintosh 1990). Rage, anger, assertion, aggression and violence are terms which all have a common core of meaning. There are, however, subtle nuances of meaning in these terms and to ignore them may be to miss the diagnosis.

The concept of violence may be limited, as in the Macquarie Dictionary definition: 'any unjust or unwarranted exertion of force or power against rights, laws...', or broadened, for example, by the statement that:

the concept of violence should allow for non-criminal activity and for the threatened as well as the actual use of outright physical force... violence is not always overt, its application may be subtle, but the effects can still be devastating. Psychological, emotional and financial abuse may be just as effective a means of subjugation, humiliation and manipulation as the use of outright physical force (Royal Australian and New Zealand College of Psychiatrists 1989, p. 1).
In view of these broad concepts, the ubiquity and increased incidence of violence, those of us involved in the direct management of individuals need a greater discrimination in the origins of that violence if we are to apply real solutions rather than an opportunistic face-saving activity. The aetiology of violence is multiple. Freud (1950) postulated that all people had a reservoir of aggressive urges of which some eventually are maladaptively displayed. Lorenz (1966), likewise, saw aggression as instinctual. Dollard et al. (1939) postulated an association between frustration and aggression, an issue that was enlarged by Berkowicz (1969). Bandura (1973) proposed a learned response; associated with this is the sub-culture of violence, which is most likely to arise in communities with economic deprivation (Hansmann & Quigley 1982). Organic brain disorders may be associated with violence (Eisenberg & Earls 1975).

With these factors in mind, one is then faced with the violent offender. For those psychiatrists conversant with the above hypotheses confusion about the individual is likely to be greater rather than lesser. By this is meant the practicalities of what to do with a plethora of information: the capacity to associate these hypotheses with the specific individual requires a complex information processing capacity. Not surprisingly, there is a reliance on the Diagnostic and Statistical Manual (American Psychiatric Association 1987) for the purpose of advising the relevant authorities what it is that psychiatry can provide. This psychiatric intervention is also confusing, as Klassen and O'Connor (1988) pointed out, in that the proportion of criminals in mental hospitals has increased, with a trend towards a medicalisation or psychiatricisation of criminal behaviour. On the other hand, de-institutionalisation of mental patients has resulted in more people at risk of committing a crime. Lastly, we may be criminalising mental disorders by arresting persons who need treatment. Under these circumstances, the psychiatrist does not have an easy task in assessment.

**Treatment of Aggression**

It should be re-emphasised that there is no treatment of aggression or violence as such. That a conference such as this should be held reinforces Eichelman's (1988, p. 32) view that 'the treatment of the violent patient has been marred by a lack of clear rationale for using a given intervention'. Further, 'Application...to treatment situations can easily fail if it is not carried out systematically' (Eichelman 1988, p. 32). Whilst he was specifically talking about drugs, the four principles that he enumerated can also apply to our present problem. These were, first, one should treat the primary disorder, second, we should use the most benign interventions when beginning empirical treatments, third, we need some quantifiable means of assessing efficacy, and four, we need to institute such trials systematically.

Again, the psychiatrist faces a problem in treating the violent offender. One has to question whether the offender, in fact, is a patient. This raises the Medusa's head of civil rights, informed consent and ethical responses to a problem. Where the psychiatrist works within a correctional setting, the defining of accountability and responsibility is a daily matter. As doctors, we
have to be clear for whom we are acting. Is it the state? Is it the institution? Is it society at large? Is it the prisoner/patient?

The management of the violent offender requires in the first instance, a containment of violence. The violence in its own right therefore, has to be defined. Is it verbal and/or physical? Is the violence secondary to a mental disorder or is it primarily derived from social, economic, political or characterological sources? Are we speaking of violence that leads to detention or are we speaking of a violence that is subsequent to detention? Is the violence specific, towards a particular object or person, or is it random? Is the violence towards self, others or property?

Within the correctional situation, a number of decisions and streamings will have already occurred. The police, the courts and remand centres, are effectively the first to determine whether the event merits some psychiatric intervention. The bizarreness of the individual or the offence, the degree of horror and revulsion that may be felt about the offence, or the consequences of determining guilt or, indeed, innocence may well result in referral. It is at this point that the offender is directed into a number of streams. These include psychiatric hospitals or prison psychiatric services. Clearly, the more serious and objectionable the offence, the more likely the offender is to be seen by a psychiatrist. The court may remand a patient for assessment in the correctional setting or effect a hospital order for assessment and treatment within a psychiatric hospital. When physical, human, attitudinal and administrative factors, preclude admission into a psychiatric hospital, remand in prison is inevitable. Given adequate resources, there is minimum objection to this, apart from the problems associated with the treatment of a remandee who refuses to comply. Where staff resources are limited both in numbers and skills, a pragmatic conclusion may be reached which does not question greater issues. Intellectual curiosity becomes difficult in a high stress situation with an excessive workload.

The objective of a psychiatric assessment is to inform the court on a range of factors, initially whether the offender suffers from a mental illness. Subsequently, opinions as to fitness to plead and criminal responsibility may be required, and finally, an assessment on sentencing issues. The court often wishes to know what avenues are available for the care of offenders with mental disorders. After sentence, continuing management of such an offender may need to be carried out within a correctional setting. The problems of self-injury, or violence towards correctional or psychiatric staff or other prisoners, may occur and require management necessitating the cooperation between correctional and psychiatric staff. As these staff come from quite different disciplines, and have different outlooks, conflicts about the approach to management occur. It is a tribute to staff who work in correctional settings that there is not greater conflict about the approach to dealing with violent offenders who form a difficult and divisive group.

It must be emphasised that assessment and management are not easy. In the first place, a proper assessment is time consuming and, in addition, staff are required to respond to the security demands of the prison system. During assessment, access to a corroborative history is difficult and at times impossible. Pertinent documents may be unavailable and interviews with
third parties are often out of the question. Arrangements for special investigations, the obtaining of a second opinion and other steps which may assist in forming a conclusive opinion may be frustrated by other imperatives in the correctional system. Often there is an overwhelming sense of concentration on the containment of the offender and under these circumstances aspects of good clinical care may be challenged.

The treatments which may be applied in such a setting may not be entirely clear. Some modalities of psychiatric treatment are powerful and have been designed for patients suffering from serious mental illnesses. Caution is needed to see that drugs and psychological modes of treatment are not misapplied where the problem is violence alone. Psychiatry, as it is a branch of medicine, is comfortable with the use of medication but this should be clearly directed at a disease process. Thus, if violence is used to define the presence of a mental illness obvious ethical problems arise. The psychiatrist is on firmer ground where mental illness is clearly present. Within a prison setting the issues are not simple and prisoners, with some aspects of their civil rights compromised, need to be protected from potential excesses of the state. In Victoria, involuntary treatment of a prisoner within the prison setting is not permitted. As a result, psychiatric staff may be left with a psychotic prisoner, devoid of insight, who requires medication but refuses and the issue cannot be forced. Invariably, this necessitates transfer to a psychiatric hospital but in the main most psychiatric hospitals are not geared to accept actively violent prisoners because of both security considerations and problems with attitudes and skills. Special units are therefore required to effect treatment and these are gazetted under the Mental Health Act. Treatment is provided within a unit that is competent and capable of providing treatment for violent offenders. Such patients may well recover from a psychotic illness and be fit to continue their sentence in prison, although involuntary continuation of maintenance medication is not possible in that setting. Staff are dependent on a patient acquiescing to treatment. Physical treatments such as electroconvulsive therapy clearly should not be provided within prison and so must be provided in psychiatric units.

Psychological treatments, the various psychotherapies and behavioural treatments can be performed within a prison setting given adequate trained personnel and the cooperation of the patient.

Types of Violence

Broadly speaking, violent offenders who come to the attention of psychiatry fall into four main groups: assaults in general (perhaps robbery with violence); assaults in the domestic setting; violence by drug offenders; and sexual assaults.

The first group may be referred to psychiatric services as a result of bizarre in the offender or in the assault itself. Essentially, the psychiatric task is determining whether the offender has a treatable mental condition and whether psychiatry has some advice to offer regarding disposition. All too frequently offenders are found to have some personality disorder where there is little indication for drug therapy, and psychological treatment would be a
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heroic task. In this group of offenders, the multifactorial aetiology of violence may be all too apparent. In trying to manage an offender one may be faced with attempting to overcome an inadequate upbringing, providing social support in terms of basic needs and addressing the impossible task of finding a sensible pursuit to occupy the offender. A psychiatrist may well be able to provide a diagnostic label, tease out some understanding of the way the offender thinks and behaves and indicate what services may be useful on release, should the offender be motivated to use them.

Other assaults occur in the domestic situation, invariably in the setting of a breakdown in relationships, with past life experiences or psychiatric illness playing a part. Again, treatment of a primary psychiatric disorder, if present, is indicated. If there is a clear psychiatric illness this may be straightforward but problems can be greater and relationships may have broken down for multiple reasons.

Violence among drug offenders is high and may be associated with drug use itself or the acquisition of money in order to obtain drugs. That an individual has a substance abuse problem indicates dysfunction in their psychological state, a primary issue which may or may not be amenable to intervention.

Sexual offences cause a particular revulsion within a community and also within the prison population, thus posing substantial problems for correctional authorities as groups of prisoners will require protection. Sex offender programs have been developed within the prison setting and in outpatient clinics. They are currently undergoing evaluation.

A major change in management now relates to those with a Governor's Pleasure disposition. These offenders have been found not guilty by virtue of insanity but have been required to be detained at a Governor's Pleasure for the security of society. Until 1991 they were held within a correctional facility, with a number of the floridly psychotic cases being detained in state psychiatric hospitals. Following the Law Reform Commission's deliberation, it was proposed that they should be transferred to secure psychiatric forensic units and this process has resulted in some five cases being held in this manner. Offenders in this group will be incarcerated for many years with their rehabilitation, no easy matter, being the task of forensic psychiatric staff.

The detainees are viewed as falling into two broad groups: those who have been chronically institutionalised within a prison setting, so developing many of the attitudes and views of a long-term prisoner, and another younger group, more recent offenders, who do not have the same degree of institutionalisation.

A number of the first group no longer have manifest psychiatric illness and, at some level, have adjusted to their institutional existence while harbouring a hope of some form of future freedom. The second group are, in the main, more floridly sick, require more active treatment and face the prospect of many years of incarceration. The present program is in its early days and raises a great number of issues. As with other groups of violent offenders the issues of prediction of violence is critical and there needs to be more research in this area. By virtue of their offence they have affected the lives of many individuals and involved a number of instrumentalities in
decisions about their future disposal. Very complex decisions have to be made about them, taking into account many different interests.

In considering this subject we have focused our attention on the offender and not other groups affected. It is not the place to deal with victims but some attention should be given to a large group of people who are often ignored. These are those who work with offenders.

Working with violent offenders can expose people to a world of psychological brutality and primitive thinking. A daily diet of containing, managing and understanding the less desirable aspects of human nature can have substantial effects on staff. There is always a risk of exposure to violence and the various forms of official response to it. Workers in such settings run a risk of becoming brutalised. Nursing and prison staff are in daily contact with the prisoners and patients and some force of character, understanding and training is needed to retain humanity when faced with an individual who may have committed a heinous crime and, in the midst of illness and distress, emits an aura of rage, despair, contempt and humiliation.

Therefore, while violence in an individual must be contained and recurrence prevented, it is necessary for workers in this field to understand violence. This requires the capacity to pay attention to the offender although this exposes workers to the psychological roots of the offender's violence. This can be daunting and systems of support involving regular debriefing is required for the welfare of staff.

Conclusions

Forensic psychiatry is one aspect of in the management of a proportion of violent offenders. While it is concerned with those who have psychiatric disorders, involvement occurs with offenders who do not have such disorders. It is important that psychiatric services are used to assist in the management of appropriate cases but a clear definition of what are appropriate cases is needed. As forensic psychiatry is only part of the process of the management of violent offenders, cooperation with other services is required to achieve a uniform program of management. There is a need for various services, legal, correctional and psychiatric, to understand each other's functions and limitations so a concerted approach to problems can be maintained. It is essential that all staff are given education and support.

References

American Psychiatric Association 1987, *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn, revised), American Psychiatric Association, Washington DC.


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