Mental Illness in Prisons: True Diagnosis or Social Control?

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DIAGNOSIS	GENERAL PREVALENCE	PRISON PREVALENCE
Axis I Disorders		
Depression/Mood Disorder	5-20%	28%
Anxiety Disorder	5%	42%
Schizophrenia	0.05%	24%
Substance Dependency	2%	18-30%
Axis II Disorders (Cluster B)		
Antisocial Personality Disorder (ASPD)	0.7-3.6%	50-70%
Borderline Personality Disorder (BPD)	0.7-2%	28%
Narcissistic Personality Disorder (NPD)	0.8-1%	7.5%
Histrionic Personality Disorder (HPD)	1.8-3%	4%

Figure 1: Prevalence of mental health diagnoses in UK Prisons (from Singleton *et al.*, 1998)

Diagnostic criteria for 301.7 Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:

(1) failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
(3) impulsivity or failure to plan ahead
(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
(5) reckless disregard for safety of self or others
(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
(7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, misireated, or stolen from another

B. The individual is at least age 18 years.
C. There is evidence of Conduct Disorder with onset before age 15 years.
D. The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.

Box 1.2 Symptoms of conduct disorder

Aggression to people and animals

1. Bullies, threatens or intimidates others
2. Initiates physical fights
3. Uses a weapon
4. Is physically cruel to people
5. Is physically cruel to animals
6. Steals while confronting a victim
7. Forces someone into sexual activity

Destruction of property

1. Sets fires
2. Destroys others' property

Deceitfulness or theft

1. Breaks into someone's house or car
2. Lies to obtain goods or favours, or to avoid obligations
3. Steals without confronting a victim

Serious violations of rules

1. Stays out at night
2. Runs away from home
3. Truants from school

Figure 2: Crime as a prerequisite for diagnosis? The DSM-IV-TR diagnostic criteria for antisocial personality disorder and conduct disorder

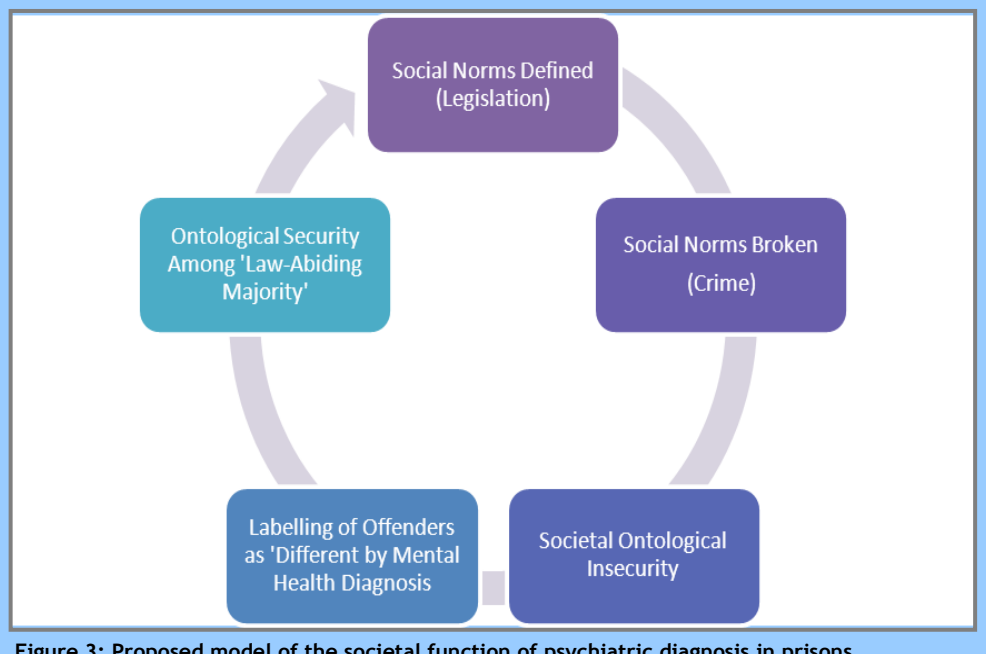

Figure 3: Proposed model of the societal function of psychiatric diagnosis in prisons

Background and Context

The Mental Health Foundation (2011) suggests that around 90% of people incarcerated in UK prisons are diagnosable with two or more mental health conditions - significantly higher than in the general population.

Singleton et al.'s (1998) widely-cited study into prison mental illness prevalence reveals particularly interesting trends with regard to Cluster B personality disorder, anxiety, and schizophrenia, and these trends appear to have translated into public opinions on the dangerousness of those with psychotic illnesses and diagnoses of personality disorder (The Information Centre, 2011).

Key Issues

There is a huge over-representation of personality disorders among the UK prison population when comparing against prevalence estimates of the general non-incarcerated population. Perhaps the most marked of these over-representations is for the diagnosis of 'anti-social personality disorder'(see Figure 1).

The correlational relationship between prisons and mental health diagnoses has been confused by many members of both the academic and (especially) non-professional communities as a causal one (Fridell *et al.*, 2008; Pappas, 2013). This is not be the case, and instead it may be wise to adopt Anckarstäter et al.'s (2009) approach of considering mental illness as an INUS (risk) factor for offending, as opposed to a causal one. This concept should be better communicated by the media and policymakers, as doing so potentially eases the reintegration process of mentally ill offenders upon release from prison – facilitating mental health recovery and desistance from crime.

Upon analysis of the clinical criteria for diagnosing antisocial personality disorder (and its childhood equivalent, conduct disorder), it is not surprising that there is such an over-representation of the former in the prison environment. The diagnostic criteria simply read as a list of potential ways of coming into contact with the criminal justice system. Within the context of stubbornly high UK reoffending rates, it is logical to suggest that a "pervasive pattern … as indicated by three (or more) of the following…" is an easy threshold to meet as a prisoner, and makes diagnosis of antisocial personality disorder virtually unavoidable within a forensic setting.

Conclusions

Psychiatric diagnosis among some of the most violent offenders within the prison population serves an important, if unfair, social and political function. By labelling these individuals as mentally ill, policy makers both relieve themselves of any blame for violent and repeated criminality, whilst simultaneously making it so they appear to be 'doing something' in response to public outcry at particularly heinous crimes (e.g. the 2001 introduction of specialist DSPD units in high-secure hospitals with practically no scientific support).

At the same time, diagnosis reassures members of the 'law-abiding majority' that there are qualitative differences between them and 'criminals', creating the illusion that offenders can be classified into neat categories.

References:

Anckartäter *et al* (2009). Mental illness is a cause of crime: The cornerstone of forensic psychiatry. *International Journal of Law and Psychiatry, 32(6),* 342-347.
Fridell, M. *et al*. (2008). Antisocial personality disorder as a predictor of criminal behavior in a longitudinal study of a cohort of abusers of several classes of drugs: Relation to type of substance and type of crime. *Addictive Behaviors, 33,* 799-811.
Pappas, S. (2013). *Long-term effects of bullying: Pain lasts into adulthood (STUDY).* Published online at http://www.huffingtonpost.com/2013/02/20/long-term-effects-of-bullying_n_2728190.html.
Singleton *et al* (1998). *Psychiatric morbidity among prisoners in England and Wales.* London, UK: Home Office.
The Information Centre (2011). *Attitudes tomental illness - 2011.* London, UK: The Information Centre for Health and Social Care.

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