

On the Willful Induction of Mental Disorder

The Correctional Service of Canada has recently acquired dependable new data on the prevalence of various kinds of mental disorder in the federal system. These were sketched in a previous issue of this periodical.⁽¹⁾ Readers learned, for example, that members of the Canadian offender population had a one-in-ten risk of being psychotic at some time during their lives and a one-in-four chance of suffering from a psychosexual disorder. The article pointed out that one in five met the dual diagnosis criteria of antisocial personality and alcohol abuse or dependence. It also appeared that offenders with a "criminal profile" were particularly likely to be mentally disordered.

The availability of such baseline data makes it possible to consider how to reduce the general level of mental disorder. Alternatively, it is now within our power to consider how the level might be increased. As reader, you may ask why the Service would want to raise the already high incidence of mental disorder. Of course, no sensible organization would wish for such a result. Yet, there is something to be gained from "inverting" a problem - as I will do in this article.

This type of argument follows good precedent: In his utopian novel *Erewhon*,⁽²⁾ Samuel Butler helps us understand something about psychopathy and personal responsibility. He invents a world in which people who admit to physical ailments are chastised and punished, whereas those who confess to moral disorders (such as drinking and fraud) are met with kindness and helpfulness. Those unable to resist the temptations of the flesh, are sympathetically assisted by the "straighteners," but those in physical pain are beaten or imprisoned. Butler uses this approach to help us see important moral and political issues in an entirely new light.

A little closer to home perhaps, we have the article by Jay Haley published in the *American Journal of Orthopsychiatry*.⁽³⁾ This piece instructs psychotherapists on how to fail. Haley argues, tongue in cheek, that since people have a remarkable ability to recover from mental disorders spontaneously, it takes skill and cunning to keep a patient needlessly in therapy. The recovering patient has to be convinced that if one symptom is relieved, a worse one will develop, that improvement is not improvement but a "flight-into health," and so on. He outlines the steps that a fully proficient therapist can take to keep a client in treatment for years. In this at once amusing and instructive article, Haley intended for his points to be reversed in order to provide a helpful outlook to would-be therapists. My aim here is similar. Let us think of how the Correctional Service of Canada could raise the level of mental disorder by 1% annually until the year 2000. Here are a few ideas. 1. Definition Mental illness can be induced in all manner of ways. There are highly effective means of promoting disorder in the individual. As will be shown in section 2 below, simple isolation and outright neglect work wonders. But this is small stuff and takes a lot of time. If senior administration intends to be efficient in raising the general level of mental disorder, it needs to undertake major actions. It is a good idea, for example, to pressure for provincial mental health legislation with very narrow and restrictive definitions of mental disorder. As a result, doctors cannot or will not certify patients. The police eventually tire of taking the troubled and troublesome to the hospital emergency rooms and lay charges instead. Such criminalization of the mentally ill is one of the best and surest ways of raising the overall level of mental disorder in provincial and federal corrections. It is exciting to think that mental disorder can be legislated and planned for and that the numbers can be

forced up by such delightfully indirect means. If general mental health services are reduced or made inaccessible, it is possible to guarantee a rise in the prison incidence of psychiatric disorder.⁽⁴⁾

2. Isolation Once persons are in the system, they need to be kept there. This takes some effort; otherwise, many will recover, and misguided judges will let them go free. Facilities for the mentally ill within remand centres should be kept in disrepair, with minimal attention to hygienic and recreational considerations. Doctors should be kept out of these places as much as possible. If they do see prisoners and prescribe medication, the prisoners should, under no circumstances, receive the medication. Lack of medication and utterly dreary conditions will avert any risk of psychiatric normality. The general principle here is to isolate the mentally disordered offender from the rest of humanity.⁽⁵⁾ A good deal can be achieved simply by having the person seen as a "nut case" or "screwball." Fellow inmates and staff can be very helpful in ensuring that a person gets off on the right foot in establishing a career as a mentally ill offender. Once the career has begun, it can gain a momentum of its own.

3. Invention Deviant psychological and sociological researchers⁽⁶⁾ have recently pointed to the fact that some mental health workers routinely "construct" or amplify mental disorder and dangerousness. This is done largely from files, which progress from pretrial assessment to presentence reports to institutional reports to parole reports. They are like snowballs coursing down a hill. They incorporate more and more information, much of it unacceptable by ordinary evidential standards. Some, but unfortunately not all, mental health workers have a keen literary bent, which can be put to good use in creating new stories from the record.⁽⁷⁾ These stories offer intelligent, if fanciful and untestable, hypotheses about the origins of mental disorder, propensity for violence, and the like. The process has been referred to as "laundering."⁽⁸⁾ The theories of deviant researchers such as those referred to above must be discredited with passion and invective. When they dare attempt to discuss the actual rather than apparent role of mental health workers in the "construction" of mental disorder, they can be "tormented"⁽⁹⁾ and said to be inept or even unethical.⁽¹⁰⁾

4. Misapplication Psychiatrists have great power to increase the magnitude of perceived mental disorder. Many categories of illness have been added over the years with the slow evolution of the 1987 edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM III-R). This in itself is helpful to the cause espoused here. But psychologists too have their own peculiar resource - their tests. Some of these tests undoubtedly measure what they are supposed to measure and do so well when properly administered and standardized. Such tests are undesirable. What is needed instead is misapplication, which often inflates the level of disorder or mental handicap.⁽¹¹⁾ Psychologists should be encouraged to test groups of individuals in uncomfortable, pressured circumstances, with instruments designed for individual application. They should be invited to make wide-ranging interpretations from projective and non-projective tests. Ideally, these tests are never standardized for correctional populations. Some of the brighter psychologists should be encouraged to invent new tests of their own and use the eventual scores to make far-ranging decisions about their clients' futures. It goes without saying that these tests should be quite sophisticated and subtle. No ordinary person should be able to see any connection between the test or scale items and any practical consideration.

5. Aprogramming This point is related to the one above. If some of the psychiatrists and the most of the psychologists are kept busy "doing assessments" and the like, few will have the time or energy to develop remedial programs. Vigilance is needed to avoid these remedial programs at all cost. People like Andrews, Bonta, Gendreau, Ross, Wormith, and Wong can yet do damage by injuring Martinson's well-founded cause. As there is every reason to believe that mental disorder increases in the

absence of well-run vocational, educational, recreational, and remedial programs, such innovative programs must be seen as impediments. It is indeed fortunate that it is very hard to establish such programs in institutions and communities, and that if they somehow take root, there are many ways to undermine them. Should results indicating the positive effects of treatment ever get into print, they can, of course, be discredited.⁽¹²⁾ 6. Uniformity The only thing that may be more successful than the absence of programming in promoting mental illness in prisoners is the adoption of a single-minded, and preferably simpleminded, approach to habilitation.⁽¹³⁾ Properly effected, this method has a prophylactic effect. A mental health professional new to the correctional sphere can enter with a "sure-fire" approach.

Administration accepts the plan because of sloth or inattention, and the project commences. It matters little what the idea is: token economies made to look novel, sex-drive-reducing medications, alteration of criminal thinking patterns. The program should not take into account any theoretical ideas of the prisoners about addiction, psychopathy, sexual disorders or major mental illness.⁽¹⁴⁾ If there is no consideration of individual therapeutic requirements, failure is virtually assured. Mentally ill prisoners need experience with failure if they are to get worse. 7. Discontinuity Inevitably, a deviant administrator, planner or researcher will occasionally get the idea of constructing a set of integrated, individually tailored programs with careful bridging between components. Fortunately, links in such a chain are seldom forged and are easy to break. It is almost assured that a schizophrenic prisoner will relapse if removed abruptly from a well-regulated therapy program and medication. There is a reasonably good chance that a sex offender treated in a Regional Psychiatric Centre can be induced to relapse by simply being discharged to the street without professional support.⁽¹⁵⁾ Not only is the patient's problem reconfirmed, but there is a possibility that those directly affected by the illness or impulsive acts will also become mentally disordered. This ensures work for future generations of mental health professionals. 8. Bouncing Some cases of mental disorder are so serious that they have to be bussed off to a hospital. Unfortunately, they become lost to corrections, at least temporarily. They go out as schizophrenic and they come back as "personality disordered."⁽¹⁶⁾ The only bright side is that, without medication and personal support, they will relapse on return. These extreme cases provide training for staff who need to improve their driving skills. Being bussed frequently from hospital to prison and from prison to hospital almost guarantees that the inmates will be overwhelmed by symptoms of mental disorder. Disorientation is a powerful device. Most of us get sick when we do not know where we are. Once in a while, some bright spark tries to put forward the idea that there should be co-operation and co-ordination among ministries and departments (e.g., Justice, Solicitor General, Health and Welfare, Housing). However, there is little fear of such developments as the careers of most senior administrators are fortunately tied to advancement within their own ministry. Of even less moment are those who waste their days seeking improved connections between federal and provincial agencies. 9. Unaccountability It is a big mistake to attempt any systematic evaluation of remedial projects. Would-be researchers should be eased out promptly with the appropriate degree of politeness. Otherwise, these people might demonstrate that the program is effective, and the workload would thus increase dramatically. While this outcome may be positive over the long run, in that the project will likely collapse under the weight of many inappropriate new referrals, it will take time. On the other hand, the evaluators may demonstrate that the program is ineffective. While this finding is good because ineffective programs actually induce mental disorder, it means looking for another job. Either way, program evaluation is for losers. The best approach, as suggested in section 6 above, is to adopt some apparently simple technique (e.g., pink walls,

megavitamins, or pet therapy) and scrupulously avoid any attempt at evaluation (i.e., do not ask inmates for opinions, avoid checks on recidivism, etc.). 10. Uninvitingness It has already been suggested that mental health professionals play a positive role by unwittingly increasing the overall level of mental disturbance. They can, for example, perceive a disorder that does not exist (section 3) or undertake program development in naive ways (section 6). Yet, as previously noted, these individuals need to be watched. Some have the misguided idea that Martinson was wrong (section 5), and the unfettered use of doctors and their medicines is undesirable (section 2). Correctional services do not need too many of these social workers, psychologists, and psychiatrists (though, truth to tell, many are quaint, and their eccentricities and excesses would be missed). Certainly, it is a mistake to let them become too comfortable.

Doctors can be kept in place by edicts designed to limit the scope of their practice. Such "guidelines" should change frequently, and their actual source should be unclear. Every time a parolee violently reoffends, a dozen psychologists should be diverted instantly from program development and evaluation to "dangerousness assessments" (or rather "risk assessments"). They will be confined to their offices, ever more isolated from life in the institution or community housing project. They will also become bored, especially if the assessments are not conducted within the context of some research plan to which they are contributing. Other indignities can be heaped on them. For instance, they could be allowed to start a project, maybe even with allocated space and resources. Once the program is operating, it must be stopped suddenly, on the flimsiest grounds possible. Another good idea is to block a staff member from giving a paper at a conference, purportedly because the material is too contentious or is against policy. Creativity must be stopped, unorthodoxy eliminated. Astute readers may see that, as mental health workers themselves are not immune to psychiatric disorders, many of the principles outlined here can be turned against would-be helpers. With a little planning, it should be possible to raise the incidence of mental disorder not just within the inmate population, but among the mental health staff as well.

How to Develop a Model for the Effective Treatment and Care of Mentally Ill Prisoners

It is not that we lack the information or even the professional assistance to treat mentally disordered offenders. But, at this point in Canada, we are only just beginning to develop the necessary outlook within federal corrections. The Mission Statement will help, as it generally addresses the issues raised in this article. Now, however, these principles need to be developed, especially as they apply to mentally disordered offenders. The Task Force will also help. So might consideration of the points sketched above. The argument is that mental disorder in the Correctional Service of Canada could be substantially *reduced* by: ⁽¹⁾ diverting at the outset cases that, by any reasonable standard, should fall within the scope of the health authorities; ⁽²⁾ ensuring that mentally disordered offenders remain connected to a wide range of services within the institution and beyond; ⁽³⁾ becoming more fully aware of the possible iatrogenic effects of psychiatric and psychological assessments; ⁽⁴⁾ ensuring that routine psychological tests are properly administered and scored and that new instruments are to the point and consistent with scientific standards; ⁽⁵⁾ selecting and training staff on the basis of ability to lead and monitor remedial programs; ⁽⁶⁾ recognizing that inmates themselves have valid ideas about the programs they want and that projects must be worked out in partnership; ⁽⁷⁾ planning with individuals over the long term for

integrated and manageable steps between programs; ⁽⁸⁾ developing correctional system resources to enable the full and responsible care of seriously mentally ill patients; ⁽⁹⁾ establishing effective ways to determine which programs work better than others for particular types of mentally ill prisoners; and ⁽¹⁰⁾ ensuring that mental health workers are allowed to play an integral role in institutional operations and planning.

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