

THE INCREASINGLY BLURRED LINE BETWEEN “MAD” AND  
“BAD”: TREATING PERSONALITY DISORDERS IN THE PRISON  
SETTING

*Donna L. Hall\**  
*Richard P. Miraglia\*\**  
*Li-Wen G. Lee\*\*\**

In New York State, Mental Hygiene Law defines mental illness as “an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.”<sup>1</sup> It has long been acknowledged that individuals suffering from active symptoms of mental illness might not be fully responsible for their actions. This concept manifests in criminal law, as with the insanity defense, and also in civil arenas. Examples include the competence to make certain personal choices, such as making wills, choosing among treatment options, and being civilly committed.

The concept of diminished personal responsibility as a result of mental illness has historically been articulated in standards regarding the insanity defense, ranging from the M’Naughten Test to the American Law Institute Test.<sup>2</sup> Regardless of the exact standard, the underlying reasoning is that mental illness, by impairing a person’s ability to think rationally or control behavior, arguably impacts the degree to which he is truly able to make choices independently and, by extension, is responsible for his behavior.

---

\* Ph.D., Deputy Director, Division of Forensics, New York State Office of Mental Health (cofodlh@omh.state.ny.us).

\*\* L.C.S.W., Associate Commissioner, Division of Forensics, New York State Office of Mental Health (coforpm@omh.state.ny.us).

\*\*\* M.D., Medical Director, Division of Forensics, New York State Office of Mental Health (cofolgl@omh.state.ny.us).

<sup>1</sup> N.Y. MENTAL HYGIENE LAW § 1.03(20) (McKinney 2010).

<sup>2</sup> M’Naghten’s Case, 8 Eng. Rep. 718 (1843) (articulating the first test for the defense of insanity); Model Penal Code § 4.01(1) (“Mental Disease or Defect Excluding Responsibility”) (1985).

The role of mental illness in individual behavior and personal responsibility, however, is far from straightforward. There are instances where mental illness and its relationship to violent or criminal behavior are clear; take for example an individual who commits an act in response to delusional beliefs. Among mental health professionals, it is well accepted that psychotic illnesses and major mood disorders, diagnoses traditionally included within the category of serious mental illnesses (“SMI”), have the potential to lead to behaviors for which an individual may not be fully responsible. These illnesses have biological factors that are documented throughout the scientific literature, and, for the most part, have established effective, if imperfect, treatment regimens comprised of medications and other therapies.<sup>3</sup> It is also known that symptoms of mental illness vary in severity and may wax and wane over the natural course of the illness. Therefore, the mere presence of a diagnosis does not necessarily equate to lack of responsibility for behavior. Mental illness may account in part or in full for behavior, or may only be coincidental to that behavior. While it is important that individuals who are unable to think rationally or control behavior as a result of mental illness are not criminally sanctioned, it is also necessary to recognize that many individuals who have mental illness can in fact function competently and rationally when not symptomatic. There are also those who function well even while experiencing mental health symptoms. No diagnosis is in and of itself synonymous with functional incapacitation, symptoms fluctuate over the course of illness, and the degree of impact varies greatly from one person to the next. In that sense, failure to recognize that individuals with mental illness can be responsible for their own decisions contributes to the stigma of mental illness.

Treatment advancements beginning in the 1970s, including improvements in psychopharmacology, increasingly supported the notion that symptoms of SMI are often transitory and controllable. Legal requirements, such as the least restrictive level of care standard in commitment criteria as articulated in the landmark case *Lake v. Cameron*,<sup>4</sup> required changes in commitment practices with advances in symptom management.<sup>5</sup> Subsequent court

---

<sup>3</sup> Philip S. Wang et al., *Adequacy of Treatment for Serious Mental Illness in the United States*, 92 AM. J. PUB. HEALTH 92 (2002) (assessing the adequacy of treatments for mental illness).

<sup>4</sup> *Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

<sup>5</sup> *Id.* at 660–62 (discussing alternatives to commitment and the level of care standard).

decisions established protections for civil commitment hearings, as exemplified by *Lessard v. Schmidt*,<sup>6</sup> which established procedural requirements, and by *Addington v. Texas*,<sup>7</sup> which established the standard of proof necessary for involuntary civil commitment.

While court decisions have increasingly protected seriously mentally ill individuals from involuntary commitment or retention in a psychiatric facility without significant due process, a series of legislative actions, bolstered by court decisions, simultaneously increased the involvement of the mental health system in the treatment and control of criminally involved individuals, particularly those diagnosed with serious personality disorders. In *Foucha v. Louisiana*,<sup>8</sup> the Supreme Court drew a seemingly clear line in ruling that an insanity acquittee, with only antisocial personality disorder and no other active mental health diagnosis, despite remaining dangerous, could not be retained in a psychiatric hospital.<sup>9</sup> But, more recently, *Kansas v. Hendricks*<sup>10</sup> upheld the use of sexually violent predator laws on the basis that the goal was to treat individuals with a mental abnormality, including anti-social personality disorder,<sup>11</sup> rather than to punish them, thereby allowing for post-incarceration detention of convicted sex offenders under the auspices of a mental health institution.<sup>12</sup>

The onus placed on the public mental health system to provide treatment for such personality disorders is compounded by the fact that courts have also required clinicians to intervene and protect third parties who are in some way at risk of harm from a patient.<sup>13</sup> While this burden appears reasonable in some circumstances where danger results from serious mental illnesses, it takes on a much more onerous nature when the patient is severely antisocial or psychopathic, both when personality disorder is the sole diagnosis, and when personality disorder overlays an additional psychiatric diagnosis.

These efforts to expand the reach of the mental health system

---

<sup>6</sup> *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated*, 414 U.S. 473 (1974) (describing commitment protections)).

<sup>7</sup> *Addington v. Texas*, 441 U.S. 418, 432–33 (1979) (holding a “clear and convincing” standard of proof necessary under the Fourteenth Amendment).

<sup>8</sup> *Foucha v. Louisiana*, 504 U.S. 71 (1992).

<sup>9</sup> *Id.* at 82–83.

<sup>10</sup> *Kansas v. Hendricks*, 521 U.S. 346 (1997).

<sup>11</sup> *Id.* at 346–47, 356.

<sup>12</sup> William Tucker, *The “Mad” vs. The “Bad” Revisited: Managing Predatory Behavior*, 7 PSYCHIATRIC Q. 221, 226 (1999).

<sup>13</sup> *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334, 343–46 (1976).

largely relate to those diagnoses—substance use disorders and personality disorders, for example—that, while contained within the Diagnostic and Statistical Manual of Mental Disorders (“DSM IV-TR”) by the American Psychiatric Association,<sup>14</sup> are not typically considered sufficient to render an individual wholly free of personal responsibility for any misdeeds.<sup>15</sup> In contrast to SMIs, there is the question of whether personality disorders are true illnesses or an extreme of normal variation.<sup>16</sup> All people have personality traits, so the question is of degree of dysfunction. In addition, while personality disorders are in part the products of prior experiences, there remains the issue of individual choice.

While increased reliance on the mental health system to treat and control antisocial behavior is largely grounded in concerns for public safety, litigation and legislative actions in New York State serve to require intensive mental health programming for some individuals diagnosed with antisocial personality disorder who experience difficulty with prison structure.<sup>17</sup> The mandates have the effect of extending the role of diagnoses previously not considered appropriate for mental health management, or at least involuntary mental health care.<sup>18</sup> They also required the mental health system to increasingly provide intensive, residential programming to treat individuals who neither have a serious mental illness, nor are necessarily identified as high-risk for suicide.<sup>19</sup> This shift in the nature of the recipient population presents a significant challenge for mental health providers who are largely trained to work with more traditionally mentally ill clients. Moreover, it raises a variety of questions concerning the appropriate boundaries—or the appropriate interactions—between mental health and correctional programming when dealing with severely personality- and behaviorally-disordered individuals without the traditional SMI diagnoses. Among obvious questions are the following:

- What types of treatment modalities work to improve the functioning of personality-disordered individuals, and what environment is needed to implement those modalities?

---

<sup>14</sup> AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed., text revision 2000) [hereinafter DSM IV-TR].

<sup>15</sup> Mary Lynn Krongard, *A Population at Risk: Civil Commitment of Substance Abusers After Kansas v. Hendricks*, 90 CAL. L. REV. 111, 113–16 (2002).

<sup>16</sup> R.E. Kendell, *The Distinction Between Personality Disorder and Mental Illness*, 180 BRT. J. PSYCHIATRY 110, 110 (2002).

<sup>17</sup> *Id.* at 2–3.

<sup>18</sup> *Id.* at 3.

<sup>19</sup> *Id.* at 7.

- What are the costs to the individual who is placed under intensive mental health programming in the absence of a SMI?
- Which system—mental health or correctional—is better equipped to provide services to severely personality-disordered individuals without SMI?

## I. HISTORY OF MENTAL HEALTH TREATMENT OF PRISONERS IN NEW YORK STATE

In New York State, the role of mental health systems in providing services to prisoners has expanded throughout the last thirty years. In 1977, with the passage of Correctional Law section 402, the Office of Mental Hygiene assumed responsibility for the provision of mental health services for persons incarcerated in correctional facilities.<sup>20</sup> Section 402 established Central New York Psychiatric Center (“CNYPC”) as the facility to serve this population.<sup>21</sup> For almost a century prior to the enactment of section 402, all correctional mental health services were provided by the New York State Department of Correctional Services (“DOCS”) at Dannemora and Matteawan State Hospitals, commonly referred to as institutions for the “criminally insane.”<sup>22</sup> Dannemora served mentally ill inmates sentenced to DOCS facilities, while Matteawan served those defendants found incompetent to stand trial or not responsible for criminal conduct due to mental disease or defect.<sup>23</sup> Matteawan also served individuals, within a parallel system of institutional care operated by the Department of Mental Hygiene (“DMH”), who were deemed too dangerous to be served in civil confinement state hospitals.<sup>24</sup>

The activism and civil rights movement of the 1960s was not limited to combating centuries of racial injustice. A series of landmark court decisions also altered the landscape in which correctional mental health services would be delivered, ultimately resulting in the New York State Legislature enacting Correctional Law section 402.<sup>25</sup> Four seminal decisions were key to the reconfiguration of New York’s correctional mental health system of

---

<sup>20</sup> N.Y. CORRECT. LAW § 402 (McKinney 2003).

<sup>21</sup> *Id.*

<sup>22</sup> *See* 1962 N.Y. Laws 2211–13; 1929 N.Y. Laws 602.

<sup>23</sup> *See id.*

<sup>24</sup> *See* 1929 N.Y. Laws 602–05.

<sup>25</sup> *See, e.g.,* *Kansas v. Hendricks*, 521 U.S. 346 (1997) (cited in N.Y. CORRECT. LAW § 402).

care. The *Baxstrom v. Herold*<sup>26</sup> and *Schuster v. Herold*<sup>27</sup> decisions led to the closure of Dannemora State Hospital; the *Negron v. Ward*<sup>28</sup> decision resulted in a consent decree leading to the Legislature's enactment of Correctional Law section 402 and the creation of the CNYPC and its network of corrections-based satellite mental health units; and the *Kesselbrenner v. Anonymous*<sup>29</sup> decision led to the opening of Mid-Hudson Psychiatric Center on the grounds of Matteawan State Hospital in 1973, ultimately leading to the closure of Matteawan.<sup>30</sup> By 1977, all forensic mental health services in New York State were provided by the recently created Office of Mental Health ("OMH").

The two decades following the enactment of section 402 brought further changes resulting in the expansion of correctional mental health services. Fiscal and public policy decisions served to fuel this growth. The confluence of a "get tough on crime" public safety initiative, the preference for community-based care as a model to serve persons with psychiatric disabilities, stricter civil commitment criteria, and federal and state funding mechanisms, encouraging community-based care over institutional care (Institutions for Mental Disease or IMD exclusion), had an unanticipated outcome for many individuals with psychiatric disabilities.<sup>31</sup> Nationwide, our jails and prisons had become increasingly populated by persons with mental illness leading the Public Broadcasting Service ("PBS") show *Frontline* to describe jails as the "New Asylums."<sup>32</sup>

In response to the changing demographics of the DOCS population, the demand for mental health services has increased over time. In 1977, CNYPC operated seven corrections-based satellite mental health units.<sup>33</sup> Today, that number stands at fifteen, with an additional fourteen DOCS facilities with enhanced mental health services.<sup>34</sup> All told, CNYPC has some degree of

---

<sup>26</sup> *Baxstrom v. Herold*, 383 U.S. 107 (1966).

<sup>27</sup> *Schuster v. Herold*, 410 F. 2d 1071 (2d Cir. 1969).

<sup>28</sup> *Negron v. Ward*, 458 F. Supp. 748 (S.D.N.Y. 1978).

<sup>29</sup> *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161 (1973).

<sup>30</sup> Douglas Martin, *Hospital Reflects Ideas on Criminally Insane*, N.Y. TIMES, June 5, 1994, § 1 (late edition).

<sup>31</sup> *Frontline: The New Asylums* (PBS television broadcast May 10, 2005), transcript available at <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/script.html>

<sup>32</sup> *Id.*

<sup>33</sup> N.Y. ST. OFF. OF MENTAL HEALTH, 2005–2009 STATEWIDE COMPREHENSIVE PLAN FOR MENTAL HEALTH SERVICES 93 (2005).

<sup>34</sup> *Central New York Psychiatric Center*, N.Y. ST. OFF. OF MENTAL HEALTH, <http://www.omh.state.ny.us/omhweb/facilities/cnpc/facility.htm> (last visited May 20, 2011).

mental health services available in fifty DOCS facilities.<sup>35</sup>

Accordingly, the mental health caseload grew in tandem with New York's prison population. At the close of the 1990 fiscal year, the prison population stood at 55,564 and the CNYPC prison-based caseload was 4483.<sup>36</sup> By 2000, the prison population had increased to 70,145 and the CNYPC prison-based caseload had grown to 7238.<sup>37</sup> Thereafter, the patterns of growth diverged. The prison population undertook a slow but steady decline, reaching 58,690 in 2010.<sup>38</sup> Conversely, the mental health caseload in prison continued to grow, reaching 7844 by 2010, and representing over thirteen percent of the prison population.<sup>39</sup>

Traditionally, public mental health services are titrated to focus resources on persons with SMIs, including schizophrenia or other psychotic disorders, bipolar disorder, major depressive disorder, obsessive-compulsive disorders, panic disorder, or post-traumatic stress disorder.<sup>40</sup> To qualify for Medicaid eligibility based upon a mental disorder, one "must have a long-standing, severe . . . mental impairment."<sup>41</sup> In New York State, approximately eighty-five percent of persons served through state-funded programs are diagnosed with a SMI.<sup>42</sup> In contrast, less than one-third of the mental health caseload in prison carries a diagnosis of SMI.<sup>43</sup> Other common diagnoses include less serious mood disorders (dysthymia, cyclothymia), adjustment disorders, and personality disorders.

While mental health services in prison provide treatment to a broad spectrum of individuals without SMI, the highest level of service is largely provided to those with SMI. CNYPC service levels

---

<sup>35</sup> *Id.*

<sup>36</sup> N.Y. State Dep't of Correctional Servs., *DOCS Reduces Inmate Backlog Held in County Jails to a Record Low*, DOCS TODAY, Jan. 2004, at 5.

<sup>37</sup> Press Release, N.Y. State Dep't of Correctional Servs., Governor's Policies Continue to "Right-Size" Prison Population (Apr. 24, 2001), <http://www.docs.state.ny.us/pressrel/2001/takedown1.html>.

<sup>38</sup> Mary Esch, *NY Prison System Open for Mentally Ill*, ADIRONDACK DAILY ENTERPRISE, Dec. 15, 2009, <http://www.adirondackdailyenterprise.com/page/content.detail/id/510244/NY-prison-system-opens-unit-for-mentally-ill--update-.html?nav=5008>.

<sup>39</sup> *Id.*

<sup>40</sup> Cynthia Shirk, *Background Paper—No. 66: Medicaid and Mental Health Services 4*, NAT'L HEALTH POL'Y REFORM, Oct. 23, 2008, available at [http://www.nhpf.org/library/background-papers/BP66\\_MedicaidMentalHealth\\_10-23-08.pdf](http://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf).

<sup>41</sup> *Id.*

<sup>42</sup> *PCS Summary Reports*, N.Y. ST. OFF. OF MENTAL HEALTH, <http://bi.omh.ny.gov/pcs/Summary%20Reports?pageval=prog-smi&yearval=2009> ("Of the 171,550 statewide clients, 146,446 (or 85.4%) have received "Severe Mental Illness/Severe Emotional Disturbance Status.").

<sup>43</sup> See Chris Sigurdson, *The MAD the BAD and the Abandoned: The Mentally Ill in Prisons and Jails*, 62 CORRECTIONS TODAY 70, 71–72 (2000).

range from 1 to 6,<sup>44</sup> with Level 1 receiving the most intensive treatment, and Level 6 requiring no services.<sup>45</sup> Persons with SMI comprise nearly three-fourths of the Level 1 designated inmates. Thus, while mental health services in prison are provided for a broader spectrum of lower-level mental illnesses than what is usually seen in the community, the prison-based system has historically directed the most intensive services to those with SMIs.

To accommodate the growing inmate population, DOCS embarked on a major capital construction initiative that included the conversion of former state psychiatric centers to serve as correctional facilities, expansion at existing correctional facilities, and the construction of new correctional facilities.<sup>46</sup> Many of the existing and new facilities were located away from urban centers in more demographically homogeneous rural locations in Upstate and Western New York. Mirroring the nationwide trend of the 1990s, DOCS also created specialized facilities to serve disruptive and behaviorally challenging inmates.<sup>47</sup> Two freestanding 1900 bed disciplinary housing facilities were constructed (Upstate Correctional Facility in Malone, New York and Southport Correctional Facility near Elmira, New York).<sup>48</sup> In addition, DOCS constructed nine 200-cell facilities at existing facilities to serve inmates placed in segregated or disciplinary housing.<sup>49</sup> These facilities came to be known as SHU-200s (“Special Housing Units”).<sup>50</sup> These disciplinary housing units were in addition to disciplinary housing units located within DOCS facilities. Inmates placed in these disciplinary housing units are confined for twenty-

---

<sup>44</sup> See Complaint at 8, Disability Advocates Inc. v. N.Y. St. Off. of Mental Health, (S.D.N.Y. May 28, 2002) [hereinafter *Disability Advocates Complaint*], available at <http://www.disabilityadvocates.info/complaints/DAIvOMHComplaint.pdf> (There is no level 5, and DOCS facilities are not required to treat inmates rated at level 6. Therefore, facilities account only for individuals between levels 1 and 4).

<sup>45</sup> *Id.* at 8.

<sup>46</sup> See *Collins: Myriad of Innovative Programs*, N.Y. CORRECTION HISTORY SOCIETY <http://www.correctionhistory.org/html/chronicl/docs2day/collins.html>.

<sup>47</sup> Press Release, New York State Department of Corrections, DOCS Opening Eight Maximum-Security Disciplinary Housing Units, <http://www.docs.state.ny.us/pressrel/1998/greenemax.html>

<sup>48</sup> CORRECTIONAL ASS'N OF N.Y., LOCKDOWN NEW YORK: DISCIPLINARY CONFINEMENT IN NEW YORK STATE PRISONS 9, 12 (2003), available at [http://www.correctionalassociation.org/publications/download/pvp/issue\\_reports/lockdown-new-york\\_report.pdf](http://www.correctionalassociation.org/publications/download/pvp/issue_reports/lockdown-new-york_report.pdf) [hereinafter LOCKDOWN NEW YORK].

<sup>49</sup> *Id.* at 10.

<sup>50</sup> CORRECTIONAL ASS'N OF N.Y., STATE OF THE PRISONS: CONDITIONS OF CONFINEMENT IN 25 NEW YORK CORRECTIONAL FACILITIES 12 (2002), available at [http://www.correctionalassociation.org/publications/download/pvp/state\\_of\\_prisons\\_1998-2001.pdf](http://www.correctionalassociation.org/publications/download/pvp/state_of_prisons_1998-2001.pdf).

three hours per day, and many have limited personal amenities.<sup>51</sup> At the height of the population growth, DOCS had the capacity to house in excess of 5000 inmates in disciplinary housing.<sup>52</sup>

The establishment of these specialized programs was not without controversy. Across the nation, inmate advocates and some correctional mental health professionals opposed the creation of these programs, claiming that such units are unconstitutional and have an adverse impact on inmates' psychological wellbeing. States including California, Ohio, and Wisconsin faced federal litigation surrounding their disciplinary housing programs.<sup>53</sup> New York was not spared. Dating back to 1985, with an inmate suicide in the SHU at Attica Correctional Facility,<sup>54</sup> OMH and DOCS have been defendants in a series of federal law suits alleging violation of the United States Constitution's Eighth Amendment prohibition against "cruel and unusual punishment."<sup>55</sup> Inmate legal advocates contend that placement in disciplinary housing constitutes a violation of the Eighth Amendment, as these units pose a substantial risk of serious physical and emotional harm, and that OMH and DOCS knowingly failed to take steps to reduce or minimize this harm ("deliberate indifference").<sup>56</sup>

The series of lawsuits began in 1980 with *Eng v. Coughlin*<sup>57</sup> (later to become *Eng v. Goord*<sup>58</sup>) regarding the conditions in the Attica Correctional Facility SHU, and the case was amended following the suicide of an inmate.<sup>59</sup> This was followed by the 1984 *Langley v. Coughlin*<sup>60</sup> lawsuit regarding conditions at the Bedford Hills Correctional Facility SHU, wherein plaintiffs alleged that inmates with SMI were routinely placed in the SHU.<sup>61</sup> In 1986, plaintiffs filed *Anderson v. Goord*,<sup>62</sup> a federal class action suit on behalf of inmates confined to the SHUs at Auburn and Green Haven

---

<sup>51</sup> LOCKDOWN NEW YORK, *supra* note 49, at 9.

<sup>52</sup> *Id.*

<sup>53</sup> CORRECTIONAL ASS'N OF N.Y., MENTAL HEALTH ALTERNATIVES TO SOLITARY CONFINEMENT, available at [http://www.correctionalassociation.org/publications/download/pvp/factsheets/Out\\_of\\_State\\_Models.pdf](http://www.correctionalassociation.org/publications/download/pvp/factsheets/Out_of_State_Models.pdf).

<sup>54</sup> *Eng v. Smith*, 849 F.2d 80, 80 (2d Cir. 1985).

<sup>55</sup> See *Eng v. Coughlin*, 865 F.2d 521 (2d Cir. 1989); *Langley v. Coughlin*, 709 F. Supp. 482 (S.D.N.Y. 1989), *appeal dismissed*, 888 F.2d 252 (2d Cir. 1989); *Huggins v. Coughlin*, 75 N.Y.2d 904 (1990).

<sup>56</sup> *Disability Advocates Complaint*, *supra* note 45, at 2.; *Langley*, 888 F.2d at 253.

<sup>57</sup> *Eng v. Coughlin*, 865 F.2d 521.

<sup>58</sup> *Eng v. Goord*, No. 80 Civ. 385S (W.D.N.Y. May 6, 1980).

<sup>59</sup> *Eng*, 865 F.2d at 523.

<sup>60</sup> *Langley*, 709 F. Supp. at 482.

<sup>61</sup> *Id.* at 483.

<sup>62</sup> *Anderson v. Goord*, No. 87 Civ. 141 (N.D.N.Y. 1987).

Correctional Facilities, and in 1987, plaintiffs filed *Huggins v. Coughlin*<sup>63</sup> in state court. The filing of these lawsuits resulted in incremental changes to the disciplinary process, as well as a requirement for the provision of mental health services to inmates confined to SHU. The *Eng v. Goord*<sup>64</sup> settlement resulted in the creation of a new treatment service at the Attica Correctional Facility, and Five Points Correctional Facility SHUs called the Special Treatment Program (“STP”).<sup>65</sup> The establishment of these STPs was the first in what would later become a significant expansion of treatment services for inmates prone to behavioral issues, and who are subject to disciplinary sanctions.<sup>66</sup> The STPs offered two hours of out-of-cell treatment to inmates with SMI.<sup>67</sup> Finally, in 2002 a coalition of inmate rights advocates and a prominent New York City law firm filed *Disability Advocates, Inc. v. OMH* in federal court.<sup>68</sup> The plaintiffs alleged that both the commissioners of OMH and DOCS, as well as seventeen DOCS superintendents and fifteen OMH satellite mental health unit chiefs, persistently ignored the mental health needs of mentally ill inmates in violation of both the United States Constitution and Federal Americans with Disabilities and the Rehabilitation Acts.<sup>69</sup> Plaintiffs and state defendants settled the litigation in 2007 in what is referred to as a Private Settlement Agreement (“PSA”).<sup>70</sup>

The PSA consolidated many of the incremental changes that resulted from settlements and court decisions related to the lawsuits noted above. Further, the PSA committed OMH and DOCS to provide a “heightened level of care,” added many new treatment modalities for inmates confined to SHU or subject to a SHU sanction, required DOCS disciplinary hearing offers to consider mental illness as a mitigating factor in handing out disciplinary sanctions, required OMH clinical testimony at disciplinary hearings, created facility-specific and joint OMH and DOCS central office oversight committees, and provided a modified

---

<sup>63</sup> *Huggins v. Coughlin*, 561 N.Y.S.2d 910 (1990).

<sup>64</sup> Stipulation of Dismissal at 9, *Eng v. Goord*, No. 80 Civ. 385S (W.D.N.Y. June 12, 2000).

<sup>65</sup> See *Anderson v. Goord*, 87 CV 141 (N.D.N.Y.); *Eng v. Goord*, 80 CV 385S (W.D.N.Y.); LEGAL AID SOCIETY, <http://www.legal-aid.org/en/lawreform/lawreform/prisonersrightsproject/activecases/mentalhealth/andersonvgoord.aspx> (last visited May 20, 2011).

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Disability Advocates Complaint*, *supra* note 45.

<sup>69</sup> *Id.* at 2.

<sup>70</sup> Disability Advocates Private Settlement Agreement, *supra* note 17.

definition of “serious mental illness.”<sup>71</sup> This definition of “serious mental illness” is more expansive than the definition of serious mental illness held by many in the mental health community. Specifically, the PSA defines serious mental illness as:

a. Inmates . . . [with] a current diagnosis or a recent significant history of [several] of the following Diagnostic and Statistical Manual IV Axis I diagnoses:

- (1) Schizophrenia (all sub-types)
- (2) Delusional Disorder
- (3) Schizophreniform Disorder
- (4) Schizoaffective Disorder
- (5) Brief Psychotic Disorder
- (6) Substance-Induced Psychotic Disorder (excluding intoxication and withdrawal)
- (7) Psychotic Disorder Not Otherwise Specified
- (8) Major Depressive Disorders
- (9) Bipolar Disorder . . .

b. Inmates who are actively suicidal or who have engaged in a recent, serious suicide attempt.

c. Inmate-patients diagnosed with a serious mental illness that is . . . characterized by breaks with reality, or perceptions of reality, that lead the individual to experience significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

d. Inmate-patients diagnosed with an organic brain syndrome that results in a significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or physical health.

e. Inmate-patients diagnosed with a severe personality disorder that is manifested by frequent episodes of psychosis or depression, and results in significant functional impairment involving acts of self-harm or other behaviors that have a seriously adverse effect on life or on mental or on physical health.<sup>72</sup>

It is primarily the inclusion of personality disorders in item “e” that expands the definition of SMI most significantly.

---

<sup>71</sup> *Id.* at 2–3.

<sup>72</sup> *Id.* at 3–4.

The PSA altered the distribution of mental health resources in two fundamental ways. First, it guaranteed a high level of services for the most behaviorally-disordered mentally ill prisoners by focusing those services on SHU inmates. In addition, the agreement resulted in the use of high-intensity mental health services for persons who may neither be suffering from a SMI, nor determined to be at a high risk for suicide.

Shortly after the PSA was entered, the New York State Legislature enacted, and Governor Spitzer signed into law, the SHU Exclusion Law.<sup>73</sup> The SHU Exclusion Law amended sections of both the New York State Mental Hygiene and Correctional Laws; codified many of the components of the PSA; added new training requirements for correction officers; expanded OMH's assessment responsibilities for inmates placed in SHU; called for the establishment of new residential treatment facilities; and gave oversight responsibilities for correctional mental health services to the Commission of Quality Care and Advocacy for Persons with Disabilities.<sup>74</sup>

The inclusion of individuals diagnosed solely with severe personality disorder among those defined as seriously mentally ill, in both the PSA and SHU legislation, represents a fundamental shift away from SMI and inmates who are actively suicidal as the top priority populations for mental health services in prison. Moreover, the PSA expanded mental health services for a population of inmates—both SMI and non-SMI—that was seriously behaviorally-disordered as exemplified by their placement in special housing.<sup>75</sup> The PSA also required OMH and DOCS to develop Residential Mental Health Units (“RMHUs”) to house and provide programming for this population of behaviorally-disordered individuals, some of whom suffer from SMI and others of whom a broader spectrum of lesser mental health issues.<sup>76</sup> In short, these initiatives made individuals with severe antisocial personality disorder a priority population for intensive mental health interventions.

---

<sup>73</sup> 2008 N.Y. Laws 1.

<sup>74</sup> 2008 N.Y. Laws 1–7.

<sup>75</sup> See *DOCS Fact Sheet: DAI Settlement*, N.Y. State Dep't of Correctional Servs. (Nov. 2007), <http://www.docs.state.ny.us/FactSheets/PDF/daisettlement.pdf>.

<sup>76</sup> *Id.*

## II. ANTISOCIAL PERSONALITY DISORDER

The DSM IV-TR identifies ten types of personality disorders falling into three clusters, namely: Cluster A—odd/eccentric (“Paranoid, Schizoid, and Schizotypal”); Cluster B—dramatic/emotional/erratic (“Antisocial, Borderline, Histrionic, and Narcissistic”); and Cluster C (“Avoidant, Dependent, and Obsessive-Compulsive”).<sup>77</sup> Antisocial Personality Disorder (“ASPD”) is by far the most commonly diagnosed personality disorder among prisoners, accounting for approximately two-thirds of all diagnosed personality disorders.<sup>78</sup> Predictably, approximately one-third of the RMHU inmates carry a diagnosis of ASPD. The disorder has a long and rather conflict-ridden history in the mental health system. According to the DSM IV-TR, ASPD is characterized by a pervasive disregard for, and violation of, other people’s rights.<sup>79</sup> The current criteria for ASPD include a behavioral pattern that begins at age fifteen and comprises at least three of the following behaviors:

- Repeated criminal acts
- Deceitfulness
- Impulsiveness
- Repeated fights or assaults
- Disregard for the safety of others
- Irresponsibility
- Lack of remorse.<sup>80</sup>

The diagnostic criteria of SMIs are primarily symptom constellations, whereas the criteria for ASPD are notable for the predominance of behaviors not clearly caused by a particular symptom. These behaviors could be considered to have a volitional, deliberate component. In terms of criminal responsibility, some states have explicitly excluded personality disorders from qualifying for the insanity defense.<sup>81</sup> Psychopathy, considered by some to be a more severe form of ASPD,<sup>82</sup> is similarly excluded for eligibility for the insanity defense by the Model Penal Code, and may in fact be

---

<sup>77</sup> DSM IV-TR, *supra* note 14, at 685–86.

<sup>78</sup> Merrill Rotter et al., *Personality Disorders in Prison: Aren't They All Antisocial?*, 73 PSYCHIATRIC Q. 337, 344 (2002).

<sup>79</sup> DSM IV-TR, *supra* note 14, at 701.

<sup>80</sup> *Id.* at 706.

<sup>81</sup> See Landy F. Sparr, *Personality Disorders and Criminal Law: An International Perspective*, 37 J. AM. ACAD. PSYCHIATRY & L. 168, 173 (2009).

<sup>82</sup> See Jeremy Coid & Simone Ullrich, *Antisocial Personality Disorder Is on a Continuum with Psychopath*, 51 COMPREHENSIVE PSYCHIATRY 426, 432 (2010).

considered an aggravating factor in sentencing.<sup>83</sup>

An alternate view of responsibility is the idea that only an unreasonable person would repeatedly engage in or resort to predatory or otherwise undesirable behavior to meet their needs and wants because society provides other acceptable means of attaining those needs and wants.<sup>84</sup> An extrapolation is the idea that only those who cannot otherwise help themselves would do what the rest of society considers abhorrent or extreme, and therefore, that behavior is not truly chosen by free will.<sup>85</sup> The danger in viewing undesirable behavior in this light is the possibility that other less extreme, but still outlying, choices will be seen as an indication of mental illness. This perspective also ignores the possibility that some individuals may engage in socially undesirable behaviors because they have found more personally expedient means of attaining their needs and wants, and there is the additional possibility that society does not truly provide accessible and accepted means of attaining needs. Nevertheless, when this alternate view is combined with concerns that the criminal justice system cannot meet public safety needs, the concept arises that the mental health system should be responsible for treating individuals until they are safe for the community.<sup>86</sup>

Indeed, concerns have been raised about the use of personality disorders, such as ASPD, as acceptable diagnoses for some form of civil management, rather than as a means of psychiatric description for clinical purposes, is simply a mechanism of extending incapacitation in situations where incarceration has been criticized as not long enough or ineffective.<sup>87</sup> This has been a concern in the United Kingdom with the treatment of dangerous offenders with severe personality disorder (“DSPD”), described in detail later in this paper.<sup>88</sup> The DSPD program, in turn, was preceded by the Dutch *terbeschikkingstelling* (“TBS”) program, which is essentially a dual-sentence of both a punitive prison sentence, determined by the

---

<sup>83</sup> Model Penal Code § 4.01(2); Stephen J. Morse, *Psychopathy and Criminal Responsibility*, 1 *NEUROETHICS* 205, 207–08 (2008).

<sup>84</sup> Morse, *supra* note 84, at 208.

<sup>85</sup> *Id.* at 208–09.

<sup>86</sup> See generally Kendell, *supra* note 16 (discussing the difficulty in determining whether personality disorders are mental illnesses).

<sup>87</sup> Alec Buchanan, *Descriptive Diagnosis, Personality Disorder and Detention*, 16 *J. PSYCHIATRY & PSYCHOLOGY* 538, 539–40. (2005).

<sup>88</sup> Judith de Boer et al., *Compulsory Treatment of Dangerous Offenders with Severe Personality Disorder: A Comparison of the English DSPD and Dutch TBS Systems*, 19 *J. FORENSIC PSYCHIATRY & PSYCHOL.* 148, 150 (2008).

extent to which the person is found accountable for actions, followed by an indefinite detention for treatment of the mental disorder connected to the original offense until no longer considered a danger to society.<sup>89</sup> To qualify for this program, the mental disorder must impact the individual's level of responsibility for the offense, the sentence must be at least four years, and there must be a high risk of re-offense.<sup>90</sup> Over the years, the number of TBS confined individuals has increased substantially, from 400 in 1975 to 1637 in 2006.<sup>91</sup> An estimated twenty percent are thought to be unlikely to ever be discharged, suggesting that the capacity will need to be further adjusted upward over time.<sup>92</sup>

### III. EFFECTIVENESS OF TREATMENT INTERVENTION WITH THE SEVERELY ANTISOCIAL

The treatment of correctional populations has witnessed significant advancements throughout the last twenty years. A plethora of research has shown that criminal attitudes and behaviors often can be changed when interventions are appropriately matched to the risk level, criminogenic needs and motivation, and learning styles of treatment participants.<sup>93</sup> Intensive interventions should be confined to persons at high risk of re-offending, and low and high-risk individuals should not be co-mingled.<sup>94</sup> Interventions intended to reduce criminality need to target individual characteristics that drive offending behaviors. Characteristics repeatedly shown as most predictive of offender recidivism include antisocial attitudes, antisocial associates, a history of antisocial behavior, and antisocial personality.<sup>95</sup> Cognitive-behavioral interventions have been shown to be the most effective means of changing these core thought processes, attitudes, and behaviors, particularly when appropriately tailored to the cognitive abilities and cultural norms of treatment participants.<sup>96</sup>

---

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.* at 148, 151.

<sup>92</sup> Anthony Maden, *Dangerous and Severe Personality Disorder: Antecedents and Origins*, BRIT. J. PSYCHIATRY s8, s10 (2007).

<sup>93</sup> D.A. ANDREWS & JAMES BONTA, THE PSYCHOLOGY OF CRIMINAL CONDUCT 286–87 (3d ed. 2003).

<sup>94</sup> *Id.* at 69.

<sup>95</sup> *Id.* at 239.

<sup>96</sup> D.A. Andrews et al., *Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis*, 28 Criminology 369, 375 (1990); Ted Palmer, *Programmatic and Nonprogrammatic Aspects of Successful Intervention*, in CHOOSING

Treatment programs that adhere to these principles have been shown to reduce recidivism upwards of forty to fifty percent.<sup>97</sup> Unfortunately, program fidelity tends to falter as programs progress from experimental, controlled settings involving researchers, to mainstream corrections, often resulting in substantially lower gains.<sup>98</sup>

Although today's correctional treatment programs are significantly more promising than in past decades, proven, effective treatment for severe antisocial personality disorder remains largely illusive.<sup>99</sup> While there are no formal measurements of "severe antisocial personality," much of the research literature has operationalized the construct as overlapping with psychopathy.<sup>100</sup> Psychopathy, as measured through the PCL-R, is comprised of two dominant constructs, including aggressive narcissism and socially-deviant lifestyle.<sup>101</sup> Measures on both domains overlap significantly with the behavioral markers defined within the DSM-IV definition of antisocial personality. Indeed, research employing measurements of both constructs indicate that they are a continuum, with psychopathy being an extreme variant of antisocial personality.<sup>102</sup>

Treatment providers often perceive severely antisocial/psychopathic patients as dangerous, deceitful, and poorly motivated.<sup>103</sup> While treatment providers routinely deal with some level of patient ambivalence, the often antagonistic and threatening nature of this population can inhibit the development of therapeutic alliances. The psychiatric literature reflects the difficulty in treating antisocial patients. According to Skodol and Gunderson, accurate identification of antisocial personality disorder is an important clinical issue due to the potential disruption of treatment

---

CORRECTIONAL OPTIONS THAT WORK: DEFINING THE DEMAND AND EVALUATING THE SUPPLY 131, 147 (Alan T. Harland ed., 1996); Mark W. Lipsey & Francis T. Cullen, *The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews*, 3 ANN. REV. L. & SOC. SCI. 297, 307 (2007).

<sup>97</sup> Andrews et al., *supra* note 97, at 374; Lipsey & Cullen, *supra* note 97, at 310.

<sup>98</sup> Lipsey & Cullen, *supra* note 97, at 315.

<sup>99</sup> Grant T. Harris & Marnie E. Rice, *Treatment of Psychopathy: A Review of Empirical Findings*, in HANDBOOK OF PSYCHOPATHY 565, 568 (Christopher J. Patrick ed., 2006).

<sup>100</sup> Coid & Ullrich, *supra* note 83, at 432.

<sup>101</sup> Robert D. Hare et al., *Psychopathy and the DSM-IV Criteria for Antisocial Personality Disorder*, 100 J. ABNORMAL PSYCHOL. 391, 393 (1991).

<sup>102</sup> Coid & Ullrich, *supra* note 83, at 432.

<sup>103</sup> JESSICA H. LEE, RISK ASSESSMENT MANAGEMENT AND AUDIT SYSTEMS: THE TREATMENT OF PSYCHOPATHIC AND ANTISOCIAL PERSONALITY DISORDERS: A REVIEW 2 (1999), <http://www.ramas.co.uk/report3.pdf>.

or of the associated therapeutic environment. However, for treating the antisocial personality disorder itself, standard psychiatric interventions may not be successful.<sup>104</sup> Similarly, Meloy argues that there is not yet treatment shown with controlled empirical research to be effective for ASPD, and he further notes that research studies on the efficacy of treatment for ASPD have varyingly found treatment to be either beneficial or to have a negative treatment effect, such as increasing violent behavior.<sup>105</sup> In either case, given the available therapeutic modalities, treatment choices are often unclear, and outcomes are even more uncertain. Psychopharmacologic treatment, when applicable, is focused on the treatment of co-morbid diagnoses, and may improve associated symptoms of personality disorder, such as mood, anxiety, or impulsivity problems, but as Meloy notes, there is no data that shows the underlying antisocial personality disorder itself can be altered with medication.<sup>106</sup> Perhaps the most confounding aspect of treatment of antisocial personality disorder is the reality of comorbidity, or the simultaneous co-existence of multiple diagnoses. While undoubtedly there are instances where antisocial personality disorder is truly the sole appropriate diagnosis, personality disorder frequently co-occurs with additional diagnoses of serious mental illness, or even other personality disorders. Where multifactorial symptoms exist, appropriate treatment intervention then becomes more challenging. A classic example is that of the emergence of personality traits as psychosis remits—as the patient becomes less impaired by hallucinations, delusions, or disordered thought processes, pre-existing personality disorders may become more prominent.

Much of what is known about the efficacy of treatment for severe antisocial personality comes from research out of Great Britain, where the government has spent over \$300 million providing mental health treatment for this population in prisons and forensic hospitals over the last ten years.<sup>107</sup> Despite intensive focus on severe antisocial personality-disordered individuals in the British

---

<sup>104</sup> Andrew E. Skodol & John G. Gunderson, *Personality Disorders*, in THE AMERICAN PSYCHIATRIC PUBLISHING TEXTBOOK OF PSYCHIATRY 821, 840 (Robert E. Hales et al. eds., 5th ed. 2008).

<sup>105</sup> J. Reid Meloy, *Antisocial Personality Disorder*, in GABBARD'S TREATMENT OF PSYCHIATRIC DISORDERS 775, 777 (Glen O. Gabbard ed., 4th ed. 2007).

<sup>106</sup> *Id.* at 782.

<sup>107</sup> Peter Tyrer et al., *The Successes and Failure of the DSPD Experiment: The Assessment and Management of Severe Personality Disorder*, 50 MED. SCI. & L. 95, 95 (2010).

correctional and mental health systems, a 2003 white paper by the Personality Disorder Treatment Review Group of the British Home Office was unable to identify any research that presented strong evidence of a significant treatment effect for severe personality disorder.<sup>108</sup> Other research has drawn even more disconcerting conclusions—that treatment can actually exacerbate criminality among severely antisocial/psychopathic individuals, as these individuals use the opportunity to further hone manipulation skills and prey on other participants and staff. For example, Rice, Harris, and Cormier compared treated and non-treated psychopaths and non-psychopaths and found that, while treatment reduced general and violent recidivism among non-psychopaths, it left untouched general recidivism, and escalated violent recidivism among treated psychopaths.<sup>109</sup> Similarly, Hare, Clark, Grann, and Thornton compared outcomes for treated and non-treated psychopaths and found that treatment participation was associated with higher levels of recidivism.<sup>110</sup> As a result of such findings, a number of jurisdictions have excluded these individuals from correctional programming.<sup>111</sup> Exclusion of this population from treatment may be premature given that there are still relatively few high-quality studies involving large samples of offenders. Moreover, particular sub-populations of severely antisocial individuals, such as those with co-occurring borderline personality disorder (“BPD”), may respond to dialectical behavior therapy (“DBT”), a cognitive behavioral therapy that focuses on teaching skills for symptom management, particularly self-harming behaviors.<sup>112</sup> DBT has proven to be effective in the community for individuals diagnosed with BPD, but it is yet to be tested with persons diagnosed as severely anti-social, particularly in the absence of BPD.<sup>113</sup> In summary, while the exclusion of severely anti-social individuals from therapy is arguably premature, large-scale investment in programming for the highly antisocial/psychopathic, such as what

---

<sup>108</sup> FIONA WARREN ET AL., HOME OFFICE ONLINE REPORT 30/03: REVIEW OF TREATMENTS FOR SEVERE PERSONALITY DISORDER 5 (2003), <http://rds.homeoffice.gov.uk/rds/pdfs2/rdsolr3003.pdf>.

<sup>109</sup> Grant T. Harris, Marnie E. Rice & Catherine A. Cormier, *Psychopaths: Is a Therapeutic Community Therapeutic?*, 15 THERAPEUTIC COMMUNITIES 283, 283, 291 (1994).

<sup>110</sup> Robert D. Hare et al., *Psychopathy and the Predictive Validity of the PCL-R: An International Perspective*, 18 BEHAV. SCI. & L. 623, 630 (2000).

<sup>111</sup> *Id.* at 641.

<sup>112</sup> Christina Evangeline Newhill et al., *Psychopathy Scores Reveal Heterogeneity Among Patients with Borderline Personality Disorder*, 21 J. FORENSIC PSYCHIATRY & PSYCHOL. 202, 213 (2010).

<sup>113</sup> LEE, *supra* note 104, at 24–26.

has occurred in Britain, is arguably equally premature.

#### IV. WHAT ARE THE COSTS?

Much of the medical community's reservations regarding treatment of severe antisocial personality as a priority mental health issue stems from the absence of a showing that the disorder is organic, and/or subject to improvement through existing treatment interventions, including medication, as well as a reluctance to appear responsible for criminal behaviors resulting from antisocial personality.<sup>114</sup> Individuals with antisocial personality disorder are often less motivated for treatment and, as noted earlier, more prone to manipulate others involved in treatment and disrupt the treatment environment.<sup>115</sup> In addition, many within the medical community and elsewhere have cautioned against the use of treatment as a means to extend control over this population when other means of control are exhausted (e.g., longer periods of incarceration and post-release supervision).<sup>116</sup>

Among the most pervasive efforts to do so has occurred in the United Kingdom. Like states throughout the United States, the United Kingdom historically allowed for the civil commitment of individuals who are a clear and present danger to themselves and/or others, and whose dangerous behavior is causally related to a mental illness for which there is some prospect of effective treatment.<sup>117</sup> A variety of legislative and policy initiatives over the last thirty years, described in detail by Rutherford, have greatly expanded the reach of the mental health system in Britain to include responsibility for the treatment of persons with severe personality disorders.<sup>118</sup> In 1983, the British government expanded the target population for involuntary hospitalization through passage of the Mental Health Act, which included "psychopathic disorder" within the definition of mental disorder.<sup>119</sup> The legislation also required that mental illnesses underlying these involuntary commitments be treatable in order to utilize involuntary

---

<sup>114</sup> *Id.* at 2, 24.

<sup>115</sup> *Id.* at 26.

<sup>116</sup> *Id.* at 7–8.

<sup>117</sup> MAX RUTHERFORD, SAINSBURY CTR. FOR MENTAL HEALTH, *BLURRING THE BOUNDARIES: THE CONVERGENCE OF MENTAL HEALTH AND CRIMINAL JUSTICE POLICY, LEGISLATION, SYSTEMS AND PRACTICE* 13–19 (2010), [http://www.centreformentalhealth.org.uk/pdfs/Blurring\\_the\\_boundaries.pdf](http://www.centreformentalhealth.org.uk/pdfs/Blurring_the_boundaries.pdf)

<sup>118</sup> Mental Health Act, 1983, c. 20, § 1(2) (Eng.)

<sup>119</sup> *Id.* § 3(2)(b).

hospitalization.<sup>120</sup> The “treatability” clause of the legislation served as grounds for many within the mental health field to oppose implementation of the Mental Health Act as it related to psychopathic disorder, claiming that psychopaths were largely untreatable, and thus inappropriate for involuntary hospitalization.<sup>121</sup> Nonetheless, by the mid-1990s, twenty-five percent of the involuntary forensic mental health commitments in Britain carried the diagnosis of psychopathy.<sup>122</sup>

British efforts to contain severe antisocial/psychopathic persons further accelerated in the mid-1990s with the advent of the Dangerous and Severe Personality Programme (“DSPP”).<sup>123</sup> As is often the case with such initiatives, the DSPP was developed in response to a particularly gruesome murder of a mother and child, and a permanent disabling of a second child, committed by an individual known to have a severe personality disorder.<sup>124</sup> The program supported development of two prison-based residential units and two forensic hospitals dedicated to the treatment of psychopathy.<sup>125</sup> Severely antisocial/psychopathic prisoners reaching the end of their penal sentence became subject to transfer to the hospital-based units where they could be retained indefinitely absent a showing of improvement of their antisocial traits.<sup>126</sup> DSPP employed the following criteria for candidate selection:

- (1) They are more likely than not to commit an offence within five years that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover;
- (2) They have a significant disorder of personality;
- (3) The risk presented appears to be functionally linked to the significant personality disorder.<sup>127</sup>

While there was no legislative authority for DSPP, it existed through a patchwork of correctional and mental health legislation to provide treatment for the severely personality-disordered population. That said, DSPP was very unpopular in the mental health community, and subject to criticism as a system of

---

<sup>120</sup> LEE, *supra* note 104, at 7–8.

<sup>121</sup> *Id.* at 2, 8.

<sup>122</sup> Maden, *supra* note 93, at s8; Tyrer et al., *supra* note 108, at 95.

<sup>123</sup> Tyrer et al., *supra* note 108, at 95.

<sup>124</sup> *See id.*

<sup>125</sup> *Id.*

<sup>126</sup> RUTHERFORD, *supra* note 118, at 56–57.

<sup>127</sup> Tyrer et al., *supra* note 108, at 95.

preventive detention thinly disguised as treatment.<sup>128</sup> These criticisms were partially addressed by the government in 2005 through enactment of Imprisonment for Public Protection (“IPP”) legislation, which provided indeterminate life sentences for persons whose crimes did not warrant a life sentence, but whose sentencing judge deemed dangerous.<sup>129</sup> Still, the mental health system remained opposed to involuntary treatment of this population, based in part on concerns surrounding its treatability. In 2007, the British government responded to those concerns through amendment of the Mental Health Act and replacement of the treatability clause with the term “available appropriate treatment,” and provided for a dual-sentence to both psychiatric hospital and prison.<sup>130</sup> By 2010, Britain had over 5800 inmates serving an IPP sentence, and 350 DSPD beds, each of which cost £200,000 (prison-based) to £300,000 (hospital-based) annually.<sup>131</sup> While beyond the scope of this monograph, a similar debate as to the cost of treatment/confinement is waging within the United States surrounding civil commitment statutes pertaining to sex offenders. With statutes in twenty-one jurisdictions,<sup>132</sup> many in the mental health community question the appropriateness of such statutes in terms of their constituting a misuse of the mental health system as a means of providing for the “preventive detention” of offenders deemed at high risk for recidivism, stigmatizing to persons with traditional psychiatric disorder, and causing the diversion of precious resources from the care of the “truly” mentally ill.<sup>133</sup>

The British experience serves to offer insight into the potential ramifications of policies that treat severe personality disorder, particularly antisocial/psychopathic personality disorder, as a priority population for mental health intervention. Unlike traditional correctional interventions, mental health interventions are arguably not as easily bounded by terms of imprisonment. If an individual is deemed to have a dangerous mental illness that is

---

<sup>128</sup> RUTHERFORD, *supra* note 118, at 53.

<sup>129</sup> *Id.* at 29.

<sup>130</sup> *Id.* at 65.

<sup>131</sup> *Id.* at 29, 56, 58.

<sup>132</sup> See Jenifer Jason, Note, *Beyond No-Man’s Land: Psychiatry’s Imprecision Revealed by Its Critique of SVP Statutes as Applied to Pedophilia*, 83 S. CAL. L. REV. 1319, 1325 & n.45 (2010).

<sup>133</sup> Howard V. Zonana et al., *In the Wake of Hendricks: The Treatment and Restraint of Sexually Dangerous Offenders Viewed from the Perspective of American Psychiatry*, in PROTECTING SOCIETY FROM SEXUALLY DANGEROUS OFFENDERS: LAW, JUSTICE, AND THERAPY 131–39 (Bruce J. Winick & John Q. La Fond eds., 2003); Mary Prescott, Note, *Invasion of the Body Snatchers: Civil Commitment after Adam Walsh*, 71 U. PITT. L. REV. 839, 860 (2010).

resistant to treatment, indeterminate sentencing or involuntary commitment are likely to be viewed as appropriate policy responses. Even well-meaning efforts to bring intensive services to this population may have unintended consequences if those services are unable to achieve the desired change. Faced with few viable alternatives, governments may resort to lengthy periods of incarceration and/or involuntary hospitalization post-completion of a sentence.

Classifying persons with severe personality disorders as seriously mentally ill may also be stigmatizing for this population. These individuals do not experience the cognitive challenges common to persons with SMIs who are entering treatment.<sup>134</sup> Conversely, they likely will not progress in treatment like those with thought or mood disorders that are often responsive to medications. They will likely have little insight into their disorder and be unwilling to engage in treatment. Mental health treatment-providers, like others in their lives, may anticipate their manipulative behavior and be more guarded in their therapeutic relationship. Moreover, placement in a mental health program may further exacerbate their unwillingness to take responsibility for their problem behaviors. Equally important, their participation may provide them opportunity to manipulate others and further hone their antisocial skills.

#### V. MENTAL HEALTH CARE OR CORRECTIONAL INTERVENTION: WHERE TO PLACE THE FOCUS?

As society grapples with the challenges of providing humane care to individuals beset with disabling psychiatric conditions, while also fulfilling its basic commitments to its citizens such as ensuring the public safety, strategies combining the expertise of the mental health community with the correctional interventions of confinement and supervision have been employed with mixed success and significant cost. Even if treatment intervention is a viable means of improving outcomes for highly antisocial individuals, the question remains whether such intervention should be carried out through mental health programming or correctional programming. The rather dismal outlook regarding responsivity to

---

<sup>134</sup> See, e.g., Alice Medalia & Nadine Revheim, *Dealing with Cognitive Dysfunction Associated with Psychiatric Disabilities*, N.Y. ST. OFF. OF MENTAL HEALTH, [http://www.omh.state.ny.us/omhweb/cogdys\\_manual/cogdys\\_hndbk.htm](http://www.omh.state.ny.us/omhweb/cogdys_manual/cogdys_hndbk.htm) (last modified Jan. 13, 2011).

treatment among highly antisocial/psychopathic prisoners may lead one to question whether there are any viable means of maintaining prisoner safety and that of others absent their long-term segregation. While this population will likely continue to present a significant challenge in prison and hospital environments, some prison systems have substantially reduced disorder and violence by focusing less on the individuals involved, and more on the prison environment.<sup>135</sup> Many aspects of prison environments make them violence-prone. High interaction in low supervision areas, inadequately trained staff, high concentration of young, long-term inmates, and little opportunity for control over individual space are among the environmental factors identified as violence-inducing.<sup>136</sup> Prisons that have sought to provide inmates with some control over their schedules and daily activities, and to encourage inmates to take responsibility for planning their term of incarceration, have lower rates of violence.<sup>137</sup> Even highly antisocial individuals are less likely to erupt into violence when those around them are invested in maintaining a low-conflict environment.<sup>138</sup>

Within the psychiatric treatment setting (e.g., hospital or secure treatment facility placement), individuals with severe personality disorders frequently disrupt the treatment environment, prey on more vulnerable psychiatrically disabled persons, and display limited responses to treatment that is oftentimes not transferable to or predictive of successful community placement.<sup>139</sup> When factoring the cost of secure psychiatric facility treatment (in New York estimated to be \$175,000 per year per resident),<sup>140</sup> the question must be asked: is this the most efficient use of public funds, especially in dire fiscal times?

Clearly, many questions remain regarding optimal, or even effective, treatment for severely antisocial or psychopathic

---

<sup>135</sup> See, e.g., Cooke et al., *Casting Light on Prison Violence in Scotland: Evaluating the Impact of Situational Risk Factors*, 35 CRIM. JUST. & BEHAV. 1065, 1072–73 (2008) (indicating that an integrated approach “led to a situation where violence in Scottish prisons is a rare event”).

<sup>136</sup> James Byrne & Don Hummer, *Myths and Realities of Prison Violence: A Review of the Evidence*, 2 VICTIMS & OFFENDERS 77, 83 (2007).

<sup>137</sup> Cooke et al., *supra* note 136, at 1073.

<sup>138</sup> Kenneth Adams & Joseph Ferrandino, *Managing Mentally Ill Inmates in Prisons*, 35 CRIM. JUST. & BEHAV. 913, 919 (2008).

<sup>139</sup> See generally Howells et al., *Challenges in the Treatment of Dangerous and Severe Personality Disorder*, 13 ADVANCES IN PSYCHIATRIC TREATMENT 325 (2007).

<sup>140</sup> N.Y. ST. OFF. OF MENTAL HEALTH, 2009 ANNUAL REPORT ON THE IMPLEMENTATION OF MENTAL HYGIENE LAW ARTICLE 10: SEX OFFENDER MANAGEMENT AND TREATMENT ACT OF 2007 18 (2010), [http://www.omh.state.ny.us/omhweb/statistics/SOMTA\\_Report.pdf](http://www.omh.state.ny.us/omhweb/statistics/SOMTA_Report.pdf).

individuals, and those individuals are not a population that fits well within purely mental health treatment models. In correctional facilities, the roles of the dual agencies of correctional and mental health staff in providing these interventions are yet to be clearly defined. Successful intervention ultimately depends in part on individual motivation and recognition of the implications for individual responsibility and societal costs.

## VI. CONCLUSION

In closing, the debate as to the most appropriate setting for serving the mentally ill prison population continues as it has for the more than a century and a half since the creation of both the nation's asylum and prisons systems. In New York, it is not a coincidence that the first prison—Auburn Correctional Facility—was followed shortly thereafter by the opening of Utica State Hospital, and that for the next several years after their openings, inmates and patients were transferred between the two institutions. Prison environments can be stressful, and a portion of the prisoner population does indeed suffer from SMI that requires, and is often responsive to, psychiatric treatment. Whether severe anti-social individuals can benefit from such treatment and whether they require the same level of mental health intervention remains an open question.