

Mental Illness and The Criminal Justice System

Alison MacPhail

Simon Verdun-Jones

Board Member, ICCLR

Professor, School of Criminology, SFU

Prepared for
Re-Inventing Criminal Justice: The Fifth National Symposium
Montreal, QC, Canada
January 2013

**International Centre for Criminal Law Reform
and Criminal Justice Policy**
**Le Centre international pour la réforme du droit criminel
et la politique en matière de justice pénale**

1822 East Mall, Vancouver, B.C./C.-B

V6T 1Z1 CANADA

Tel/Tél: + 1 604 822 9875

Fax/Télé: + 1 604 822 9317

Email/ Courriel: icclr@law.ubc.ca <http://www.icclr.law.ubc.ca>



We are pleased to share this information with you and encourage you to use this document for research purposes. Please ensure that all credits are acknowledged when using all or any of the information in this document. Commercial reproduction is strictly prohibited.

MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM

(Note: This paper does not address issues relating to offenders who are found not criminally responsible)

SUMMARY

Experience tells us, and research confirms, that people with various forms of mental illness¹ are highly over-represented in the criminal justice system. What is not as clear is the exact relationship between mental illness and criminal behaviour, including violence, and how best to reduce offending in people with a mental illness who have come into contact with the criminal justice system.

While many studies have identified an apparent link between mental illness and both violence and recidivism, other research has found that serious mental illness (primarily schizophrenia and other psychoses) alone is not significantly predictive of criminal behaviour. The more important factors are antisocial personality, psychopathy, neuro-cognitive brain impairments and substance abuse, as well as having antisocial associates and living in a chaotic and antisocial environment with few positive social supports.

The issue is confused by the use of the term “mental illness” sometimes to mean only the serious psychotic disorders, including schizophrenia, and at other times to include all of the various conditions listed in the DSM-IV², including antisocial personality disorder and substance abuse.

The psychoses, including schizophrenia, are typically amenable to traditional mental health treatment including drug therapy to manage the symptoms of the illness. However the factors more directly related to criminality, including substance abuse, personality disorders, developmental disorders and neuro-cognitive impairments, are not responsive to traditional mental health treatment. Cognitive-behavioural programs appear to be the most effective, which are more typically provided by community corrections rather health.

This has important implications for both the criminal justice system and the health system. It is important to treat the mental illness, but the other factors that are more directly responsible for the criminal behaviour, including the individual’s environment and social supports, must also be addressed.

¹ The terms “mental illness” and “mental disorder” seem to be used interchangeably in the literature.

² Diagnostic and Statistical Manual of Mental Disorders

OVER-REPRESENTATION

Although the precise degree of the over-representation of people living with mental illness in the justice system is uncertain, there is no doubt that it exists and is significant. Different studies use different definitions of mental illness, but when the broadest definition is used, including antisocial personality disorder and substance abuse, 80 – 90% of offenders have a diagnosis of mental disorder (Andrews et al, (2010). The most frequent diagnosis is antisocial personality disorder, which Ogloff (2006) has estimated could be as high as 60-80% of the prison population. Other research has confirmed the high prevalence of conditions such as Fetal Alcohol Syndrome (FASD), developmental disabilities, low IQ, and brain injuries (organic and acquired) (Ogloff, Davis, and Somers, 2005), although these conditions are infrequently diagnosed.

It is not surprising that there is such a high incidence of antisocial personality disorder in corrections populations, both in institutions and in community, since the disorder is defined largely in terms of behaviour which includes, for example, failure to conform to social norms including behaviour which constitutes grounds for arrest, rule breaking, deceitfulness, impulsivity or failure to plan ahead, irritability and aggressiveness, and disregard for safety of self or others. By definition therefore, the majority of people in the criminal justice system meet many of these criteria.

However much of the expressed public concern and focus is on those with a serious mental disorder, primarily schizophrenia or other psychosis.

LINK BETWEEN SERIOUS MENTAL ILLNESS AND CRIMINALITY

The Mental Health Commission of Canada noted in its report that it is important to remember that the vast majority of people living with mental health problems and illnesses do not commit crimes. In fact they are much more likely to be the victims of violence than perpetrators (Mental Health Commission of Canada, 2012). And while there is a strong public perception that mentally ill people are dangerous, a 2001 study (Stuart and Arboleda-Florez) found that in fact less than 3% of violent offences were attributable to people with only a serious mental illness (that is, without co-occurring substance use disorders).

Serious mental illness is relatively rare, both in the general population and in the justice system, but the over-representation of people with serious mental illness in the justice system is significant. A 2001 Canadian study found that while the prevalence of schizophrenia in the general population is about 0.5%, the rate in provincial prisons in Canada was 1.5% while in federal institutions it was 2.2%, with 12% overall meeting the criteria for a serious mood or psychotic disorder (Brink et al, 2001). Fazel and Danesh (2002) found that, “typically about one in seven prisoners in western countries have psychotic illnesses or major depression”.

At the same time there is extensive research that finds that the existence of a serious mental illness alone, without a co-occurring substance use disorder, is not linked to an increased likelihood of criminal behaviour, or of recidivism (Somers 2005, 2008, Skeem et al 2010, Andrews and Bonta 2010).

While the research has tended to focus on male offenders, it seems clear that women in the justice system experience even higher rates of serious mental illness, although lower rates of antisocial personality disorder.

Relationship to police

It is clear that police time is disproportionately consumed dealing with people living with a mental illness. However a significant proportion of this is due to behaviour that is not criminal. It may be in relation to seeking assistance in a crisis, or the behaviour may not be significant enough to justify arrest and criminal processing, but which is still viewed as problematic in the community. As well, this group consumes a disproportionate amount of health resources, through repeat visits to hospital emergency rooms and primary care physicians, as well as various other social services.

Some police departments have said that they would rather see increases to mental health and social services than increases to the policing budget, but this presents difficulties when policing is largely a municipal responsibility while mental health services are a provincial responsibility.

With respect to arrest, most studies seem to show that people with mental illness are not arrested more frequently than others committing the same offences. Indeed there is some suggestion that police are less likely to arrest if they suspect a mental illness, especially if they can divert to a mental health program, and when they do arrest it is sometimes because the mental illness is not identified or suspected. However when they do arrest a suspect with a mental illness, force is used more often (Engel and Silver, 2001).

Generally the research finds that people with mental illness come into the justice system for the same reasons as those without mental illness, that is, they are committing criminal offences (Becker et al, 2011).

Administration of justice offences

Once in the system, there are mixed findings with respect to whether people with mental illness are more likely to be charged with administration of justice offences. Skeem (2010) suggests that in the case of parole in the US, there seems to be a greater willingness to intervene in the absence of a new offence, and proceed with a breach charge to prevent perceived likelihood of re-offending.

However Somers (2005) found that in British Columbia, people with a mental illness alone are not more likely to be charged with administration of justice offences than those without a diagnosed mental illness. On the other hand, those with a substance use disorder were more likely to be charged, and those with a co-occurring mental disorder and substance use disorder were even more likely to be charged with this type of offence.

Risk Factors for criminality and recidivism

Corrections research over the past 20 years has sought to identify the key factors associated with criminal offending in order to develop interventions that are most likely to reduce recidivism and prevent crime. This research suggests that the four key factors associated with criminal offending and recidivism are:

- an established history of benefitting from criminal activity;
- a social environment that encourages and tolerates crime and criminals;
- personal attitudes and values supportive of criminal behaviour; and
- a personality style that finds impulsive, high risk behaviour rewarding (Bonta and Andrews, 1998, p.138, quoted in Skeem et al, 2010, at p.116).

The next most relevant group of factors include the social environment, including family and employment, as well as substance abuse. Serious mental illness is next on the list of criminogenic factors, but with only a small impact on criminality once the other factors are accounted for.

So how do we explain the significant over-representation of individuals with a serious mental illness in the criminal justice system if in fact there is only a limited causal connection between serious mental illness and crime?

Serious mental illness and co-occurring disorders or factors

A number of researchers argue that the apparent relationship between severe mental illness and violence is misleading, and that researchers have ignored the existence of “confounding variables”, that is, important factors or characteristics which are known to be related to violence which are intertwined with the mental disorder (Hiday, 2006).

Hiday suggests that the four key factors known to be related to violence are substance abuse, psychopathy or anti-social personality disorder, victimization, and community disorganization. With the exception of victimization, these are identical to the factors that are associated with criminality in the population without a serious mental illness. Psychopathy and anti-social personality disorder are recognized as highly predictive of violence for both offenders with a serious mental illness and those without such an illness (Crocker, et al, 2005, Rice and Harris, 1995).

In a study of arrests over a 10 year period of people with schizophrenia or related psychosis and a prior arrest history, McCabe et al (2008) found that the presence of any co-occurring disorder increased the risk of arrest for all offence categories. The study concluded that criminal risk assessments and clinical management in this population should focus on co-occurring antisocial personality disorder and substance use disorders in addition to treatment for the serious mental illness.

A number of researchers have identified a link between prior violent victimization of the mentally ill with violent offending. People with mental illness are significantly more likely to be victims of both violent and non-violent crimes, for a variety of reasons including their symptoms (which may make them vulnerable), homelessness and alcohol abuse (Teasdale, 2009). Prior experience of violent victimization may make them more likely to respond violently in situations where they feel threatened.

With respect to the frequency of offending, Somers (2008) found that although the number of corrections admissions is significantly higher for mentally ill offenders, when you separate out those with a mental disorder alone from those with any substance use disorder, mental disorder alone is not associated with increased risk of repeat offending relative to those people with no psychiatric diagnosis of any kind. In contrast, a substance use disorder (with or without a co-occurring psychiatric disorder) is associated with a significantly greater risk of corrections recidivism.

It appears that what drives repetitive criminal behaviours is the same, whether or not a person has a serious mental illness: that is, certain personality disorders, various forms of neurocognitive impairments, characterized primarily by impulsivity (essentially, the same neurocognitive impairments which are associated with substance abuse) as well as anti-social associates and environments.

As well, many studies indicate that mental disorder, substance abuse and violence occur more frequently in socially disorganized communities, as do stressful life events and impaired social supports. Severely mentally disordered individuals who reside in such communities learn to be violent in just the same manner as non-mentally disordered individuals. Unfortunately people diverted or released from the criminal justice system are frequently returned to these kinds of communities where they encounter all of the same factors and influences which led to them committing criminal acts in the first place (Hilday, 2006, Silver, 2006, Yakimchuk, Verdun-Jones, Brink, 2009).

SERIOUS MENTAL ILLNESS AND VIOLENCE

While much violent offending by offenders with a serious mental illness is better explained by factors which are also predictive of violence in the population without such an illness, there remains a small sub group – Skeem (2010) suggests perhaps one in ten - whose violence appears directly related to their mental disorder.

Violence is frequently associated with first episode psychosis, with more serious violence associated with longer periods of time where patients have experienced symptoms without receiving treatment (Lang and Nielssen, 2011).

While the number of individuals in this category may be small, the nature of the violence may be particularly extreme and shocking. Early identification and treatment of this group should thus be a priority, and connecting this group of individuals with mental health treatment is critical.

WHAT ARE THE MOST EFFECTIVE STRATEGIES WITH RESPECT TO MENTALLY ILL OFFENDERS?

In their 2010 paper, Skeem *et al* reviewed the evaluations of a number of different criminal justice/mental health initiatives, including the use of integrated teams, the use of Integrated Dual Diagnosis Treatment, jail diversion, and specialty probation. They concluded that the rate of re-arrest is not significantly affected by either the linkage of offenders to mental health treatment, or by treatment that reduced their clinical symptoms.

Where there were modest reductions in recidivism, the authors suggest that this is likely because some programs targeted criminogenic needs in addition to the serious mental illness. As a result, the authors conclude that good health outcomes (eg reduced hospitalization, improved symptoms) will not necessarily reduce criminal behaviour, and suggest that what is needed are interventions that specifically target that behaviour. This means strategies that target anti-social attitudes and behaviour, as well as substance abuse, which are largely cognitive-behavioural interventions.

Finally it will be critical to address the offender's environment and social supports. It is important to address the whole social context of the mentally ill offender, in particular, reducing the environmental stressors (poverty, disorganized neighbourhoods, victimization), which exacerbate the risk factors.

A recent evaluation in BC of the impact of providing housing and positive social supports to mentally ill offenders with a 10 year history of contact with the justice system has found that the provision of housing and support, even in the absence of specific mental health treatment, reduced arrests by 75% and resulted in reduced costs to not only the criminal justice system but also the health and social service systems. This recognizes the reality that without a basic level of social support, interventions designed to address mental illness or criminality are unlikely to be successful.

Some studies have shown improvements where there is effective cooperation among the different service providers (Hetherington, 2012, Reuland, et al, 2009)). As well, research suggests that integrated teams are most effective when there is

some one individual with authority across institutional boundaries (Vogel, et al, 2007).

This is absolutely not to say that the mental illness should be ignored. Early mental health intervention as well as social services including housing and supports should substantially reduce the population of people with mental illness who come to the attention of the justice system, in particular the police. Timely identification and treatment of psychosis is critical, and people who experience acute psychotic episodes should be admitted to psychiatric hospitals, and where they are in custody, be transferred from prison to psychiatric hospitals.

As well, the literature recognizes that mental illness must be addressed in order for people to respond to interventions in relation to the other factors – what Bonta and Andrews call “responsivity.” Even if people with a serious mental illness rarely offend because of their illness, their illness is often a barrier to participation in cognitive-behavioural interventions, and must be addressed as a pre-requisite or a companion intervention.

There also need to be more gender specific mental health interventions as research suggests that not only is there a higher level of serious mental illness among women in the justice system, but it tends to be undiagnosed.

With respect to substance abuse, the Mental Health Commission of Canada (2012) notes that substance abuse can mask the symptoms of a mental illness but for those who are known to be mentally ill, it makes psychiatric symptoms worse. As a result people with concurrent disorders generally have more complex problems and are more difficult to help because they often exhibit more disruptive behaviours, are less accepting of treatment and are more prone to relapse than those whose mental illness is not compounded by addiction or vice versa.

The Commission finds that typically treatment of co-occurring disorders has either been partial – focusing on only one of the problems, or sequential – dealing with first one problem then the other, or parallel – dealing with both problems at the same time, but separately. All with less than satisfactory results.

The Commission suggests that the literature on best practices recommends that mental health and addiction programs screen clients for both problems. It calls for integrated treatment – both problems are treated simultaneously, by the same team, using compatible techniques and philosophies.

SUMMARY

1. If you are in the criminal justice system there is a high probability that you have a mental illness of some type.

2. The terminology is confusing because the broad term “mental illness” includes serious mental illnesses as well as substance abuse, personality disorders and neuro-cognitive impairments. Offenders may have a number of co-occurring disorders.
3. In a very small percentage of the offender population with a serious mental illness, perhaps one in ten, there is a very clear and direct link between the mental illness and the offending.
4. Criminality and violence are closely associated with substance abuse, personality disorders and neuro-cognitive impairments.
5. The majority of offenders with a serious mental illness have additional risk factors that mediate or interact with the illness to cause offending, particularly antisocial personality disorder and living in antisocial or disorganized communities with no social supports.
6. Women in the justice system experience even higher rates of serious mental illness than men, but are often not diagnosed.
7. The criminal justice system needs to address both serious mental illness and the other risk factors.

RECOMMENDATIONS:

1. Ensure that diversion strategies, sentencing and case management address criminogenic factors such as antisocial personality/psychopathy and substance abuse, as well as social welfare needs, in addition to connecting offenders to appropriate mental health treatment.
2. Given the correlation between mental illness and substance use disorder, including the likelihood that substance misuse may mask a mental illness:
 - integrate treatment strategies, at the same time as addressing the environmental factors such as inadequate housing and supports, and
 - integrate criminal justice responses, such as drug courts and mental health courts.
3. Address the complex issues facing mentally disordered offenders through the use of integrated teams with members from mental health, social services and criminal justice. To ensure effective coordination of services, ideally authority to ensure access to required services should reside in a single individual.
4. Particular attention needs to be paid to the specific needs of women offenders.

Bibliography

Andrews, D.A., Bonta, J, (2010) *The Psychology of Criminal Conduct* (5th ed)

Becker, M., Constantine, B., Andel, R., & Boaz. (2011). Gender differences and risk of arrest among offenders with serious mental illness. *Journal of Behavioral Health Services & Research*, 38(1), 16-28. DOI: 10.1007/s11414-010-921217-8

Bonta, J., Law, M., & Hanson, K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, 123, 123-142.

Brink, J., Doherty, D., Boer, A., (2001) *Mental Disorder in Federal Offenders: A Canadian Prevalence Study*, *Int. Journal of Law and Psychiatry*.

Crocker, A. G., Mueser, K. T., Drake, R. E., Clark, E. E., McHugo, G. J., Ackerson, T. H., & Alterman, A. I. (2005). Antisocial personality, psychopathy and violence in persons with dual disorders: A longitudinal analysis. *Criminal Justice and Behavior*, 32(4), 452-476.

Engel, R.S., Silver, E., (2001) *Policing Mentally Disordered Suspects: A Reexamination Of The Criminalization Hypothesis*. *Criminology* Volume 39, Issue 2, pages 225–252.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *Lancet*, 359, 545-550.

Fisher, W., and Drake, R., (2009) *Rethinking Diversion Interventions for Persons with Co-Occurring Mental Illnesses and Substance Abuse*. New Brunswick, NJ: Center for Behavioral Health Services and Criminal Justice Research.

Harris, A., and Lurigio, A.J., *Mental Illness and Violence: A Brief Review of the Research and Assessment Strategies*. *Aggression and Violent Behavior*, Vol:12, Issue 5, 2007, pp542-551

Hetherington, V., (2012). *Inter-Agency Cooperation and Joined-Up Working in Police Responses to Persons with a Mental Illness: Lessons from New South Wales*.

Hiday, V.A., *Putting community risk in perspective: A look at correlations, causes and controls*. *International Journal of Law and Psychiatry*. Volume 29, Issue 4, July–

August 2006, Pages 316–331.

Junginger, J, et al, (2006) Effects of serious mental illness and substance abuse on criminal offenses: <http://ps.psychiatryonline.org/article.aspx?articleid=96795>

McCabe, P.J., Druhn, N., Roy-Bujnowski, K.m., Grudzinskas A.J., Arrest Types and Co-occurring Disorders in Persons with Schizophrenia or Related Psychoses: J Behav Health Serv Res. 2012 Jul;39(3):271-84.

Mental Health Commission of Canada, 2012

<http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf>

Ogloff, J. R. P., Davis, M. R., & Somers, J. M. (2005). Mental Disorders, Substance Use, and Criminal Justice Contact: A Systematic Review of the Literature. British Columbia Ministry of Health Services.

Ogloff, J., (2006). Psychopathy/Antisocial Personality Disorder Conundrum, Aust N Z J Psychiatry, June 2006 vol 40, no 6-7, 519-528

Reuland M., Schwarzfeld, M., Coun, L.D., (2009) Law Enforcement Responses to People with Mental Illnesses: A Guide To Research-Informed Policy And Practice, Council of State Governments Justice Center, NY, NY

Rice, M.E., & Harris, G.T. (1995). Violent recidivism: Assessing predictive validity. Journal of Consulting and Clinical Psychology, 63, 737-748.

Skeem, J.L, Manchak, S., Peterson, J.K., (2010) Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction.

Silver, E., et al, (2008). The Relationship Between Mental Health Problems and Violence Among Criminal Offenders

Somers, J.M., Cartar, L, Russo, J, (2008), Corrections, Health and Human Services: Evidence-Based Planning and Evaluation, Centre for Applied Research in Mental Health and Addiction, Simon Fraser University

Somers, J.M., Jones, W., Queree, M., (2005) Mental disorder, Substance use and Criminal Justice Contact: Linked Data Analysis. British Columbia Ministry of Health Services.

Stuart, Heather L.; Arboleda-Flórez, Julio E. Psychiatric Services, Vol 52(5), May 2001, 654-659

Teasdale, B., Mental Disorder and Violent Victimization. Criminal Justice and Behavior May 2009 vol. 36 no. 5 513-535

Vogel, W.M., Noether, C.D., Steadman, H.J., (2007) Preparing Communities for Re-Entry of Offenders with Mental Illness: The ACTION Approach.

Yakimchuk, R., Verdun-Jones., Brink, J. (2009). Geographic risk Management: A Spatial study of mentally disordered offenders discharged from forensic psychiatric case. *International Journal of Forensic Mental Health*, 8:148-168.