This PDF is a selection from a published volume from the National Bureau of Economic Research

Volume Title: Controlling Crime: Strategies and Tradeoffs

Volume Author/Editor: Philip J. Cook, Jens Ludwig, and Justin McCrary

Volume Publisher: University of Chicago Press

Volume ISBN: 0-226-11512-7

Volume URL: http://www.nber.org/books/cook10-1

Conference Date: January 15-16, 2010

Publication Date: September 2011

Chapter Title: Comments on "Mental Health Treatment and Criminal Justice Outcomes"

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Chapter URL: http://www.nber.org/chapters/c12101

Chapter pages in book: (p. 207 - 212)

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Comment Jeffrey Swanson

The link between mental illness and crime, and whether interventions for one may affect the other, remain challenging topics for research and public policy. Frank and McGuire elucidate key conceptual issues, take stock of relevant literatures, and point the way toward needed future research at the interface of the mental health and criminal justice systems. They also make an important empirical contribution in their own right, offering fresh data analyses to quantify the role of youthful antisocial conduct in later criminal justice contacts, and the net association of mental illness and substance abuse with adults' lifetime probabilities of arrest. Still, their chapter provokes reflection on whether *any* attempt to make broad, general statements about the impact of mental illness and its treatment on crime is bound to come up short.

At the outset, Frank and McGuire distill a complex set of problems into a simple, and seemingly testable, syllogism: If *(a) mental illness causes crime, and (b) mental health treatment reduces mental illness, then (c) mental health treatment reduces crime.* Given evidence for these crisp propositions, the policy implication would clearly follow: *to reduce crime in society, we must increase access to mental health treatment.* In particular, Frank and McGuire entertain the conclusion that people with mental illness who are involved with the criminal justice system should be provided better access, more extensive treatment, and should be subject to sanctions against not adhering to treatment.

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The trouble with the syllogism is not its internal logic but, as Frank and McGuire themselves imply, the elastic meaning of its key external referents—the very subjects and predicates of mental illness, crime, and causation. Serious psychopathology, considered broadly and over the life course, may encompass acute disorders of thought and mood, but also chronic disorders of personality, behavior, and social functioning—even addiction disorders. Crime, for its part, encompasses a vast array of illegal actions that vary widely in their causes and consequences and associated sanctions. And as for the causal arrows between them, over time these tend to run in both directions, take meandering routes, and interact with an untold number of messy variables in the social environment.

That the definitional boundaries of mental illness and crime *overlap* is a semantic problem but hardly a trivial one, insofar as semantics both shape and reflect consequential behavior and interaction—in particular, that of social actors charged with identifying, classifying, controlling, and "treating" deviance. Thus, some illegal behaviors (drug abuse, for example) are also considered pathological, and some psychiatric diagnoses (conduct disorder, for example), may incorporate illegal behaviors as significant indicia. Whether and why particular problems are, in any case, actually *treated* as illnesses, *punished* as crimes, or *controlled* as social threats (or some combination of these) are matters that go beyond the inherent features of behavior; rather, the determination of who gets which interventions may reflect prevailing ideologies and norms; the corresponding organization and financing of social service systems that are designed to uphold such norms and manage those who break them; and, not infrequently, disparities of power and resources and capital in social hierarchies.

More specifically, the intersection of crime and mental illness is a liminal space inhabited by people who could go in either direction—into the mental health service system or into the criminal justice system. In theory, of course, people can receive treatment within the justice system, or justice sanctions within the treatment system. Sometimes involvement in one is used to "leverage" the other; a commitment to enter treatment may be used as a lever to reduce a criminal sentence while, conversely, the threat of a sentence may be used to motivate treatment participation.

The conceptual framework of *therapeutic jurisprudence,* as discussed briefly by Frank and McGuire, represents a set of theoretically driven policies that combine treatment with sanctions. Still, at their core, criminal and mental health interventions remain distinct; they serve different basic purposes, for largely distinct populations, and need to be targeted appropriately. This complicates Frank and McGuire's implicit argument that mental health treatment should substitute wholesale for incarceration of people with serious mental disorders.

Frank and McGuire might have considered several alternative syllogisms,

which comprise somewhat more complex but relevant hypotheses about the effects of both criminal justice and mental interventions:

Syllogism 1: If (a) some crimes committed by persons with mental illness are not caused by mental illness, and (b) mental health treatment does not reduce other causes of crime, then (c) mental health treatment does not reduce all crimes committed by persons with mental illness.

Syllogism 2: If (a) incarceration prevents crime directly by incapacitating people who would otherwise commit crimes, and (b) some people with mental illness are inclined to commit crimes and are incarcerated, then (c) incarceration prevents crime in some people with mental illness.

Syllogism 3: If (a) the threat of incarceration deters crime in rational actors, and (b) some persons with serious mental illness who commit crimes are not *rational actors, then (c) threat of incarceration does not deter crime in all persons with serious mental illness.*

To illustrate, consider a person diagnosed with schizophrenia who commits minor crimes (such as trespassing or disturbing the peace) because she is cognitively impaired, addicted to alcohol, homeless, and wandering the street. Arresting and incarcerating such an individual would serve the immediate interest of public safety by incapacitating a person who might otherwise continue to commit minor crimes. However, there is little reason to expect that, without treatment, any threat of future incarceration would deter such a person from committing the same sorts of crimes upon reentering the community. Alternatively, in such a case, involuntary hospitalization followed by outpatient commitment would serve an equivalent public safety function while also providing treatment, which, in turn, should reduce the likelihood of future crime stemming from the person's acute mental illness and addiction; such is the basic idea underlying many jail diversion programs for justice-involved people with serious mental illness and substance abuse comorbidities. For this clinical population, then, alternative or leveraged mental health treatment—whether inpatient, outpatient or both—may be seen as a sensible crime-prevention policy.

Now consider the very different case of a person with mental illness who is engaged in a lengthy criminal career that is *not* driven by mental illness, but rather follows on a history of antisocial conduct dating back to childhood. In this case, there is little reason to expect that treatment for acute mental illness *per se* would reduce the person's risk of recidivism; indeed, treatment might conceivably *increase* a person's ability to commit crime more effectively. Sorting out these very different kinds of cases is essential for understanding the nature and scope of the problem of crime and mental illness and, ultimately, deciding what to do about them.

There are several ways to think about the scope of the problem of mental illness and crime in society. First, from a broad, longitudinal, social-

epidemiological point of view, we would operationally define what counts as mental illness, what counts as crime, and assess their unique and overlapping prevalence in the total population. We would also examine a range of covarying risk factors in relevant domains, assess which comes first in any given case—mental illness or crime—and consider the possible causal role of each in determining the other. Second, from a mental health services and policy point of view, we would start with psychiatric patients—those receiving treatment in various settings—and examine the extent to which antisocial behavior and criminal involvement occur among these patients. And from a criminal justice point of view, we would start with criminal offenders—people who have been arrested, are incarcerated, on probation, or parole—and examine the occurrence of mental illness in these populations.

With respect to the scope of the problem of *mental illness within the justice system,* Frank and McGuire allude to the argument that big city jails have become the new asylums—a tragic testament to the failures of deinstitutionalization and the ill-fated community mental health care system. They cite an estimate by the Treatment Advocacy Center that 1,400 mentally ill individuals inhabit the Los Angeles County Jail on any given day. This appears to be a very large number, but the broader context is that there are between 5,000 and 7,000 inmates in the Los Angeles County Jail population—the largest in the country—and that these are among 2.4 million incarcerated individuals in the United States (Bureau of Justice Statistics 2010).

Even if *all* the people with serious mental illness were released from criminal justice institutions, there would still remain close to two million people in jails and prisons in the United States, which has the highest rate of incarceration among its peer countries. This means that public mental health policy can expect to have only a small impact effect on the overall problem of crime, even if it were to succeed at expanding treatment to people with mental illness, and even assuming that "mental illness causes [some] crime" and "treatment works."

Violent behavior toward others is perhaps the most troubling type of crime and the most closely associated with mental illness in the public mind. And yet the best available data from the United States suggest that only three to five percent of violence acts are attributable to serious mental illness (Swanson 1994).

To ask the question the other way, what is the scope of the problem of *crime and criminal justice involvement in the population with serious mental illness*? Frank and McGuire answer this in their new data analysis mainly by focusing on the overall lifetime arrest rate of people with serious mental illness. This analysis unavoidably combines in a single index vastly different types of illegal behavior, and mixes together those where crime preceded mental illness and vice versa. While a valid gauge of the magnitude of criminal justice involvement, the measure is too blunt to tell us precisely

what criminal justice involvement actually means in this population, or what should be done about it. A previous study of patterns of arrest among people with serious mental illness in North Carolina found that 20 percent were arrested over a period of twelve months. However, serious violent crimes accounted for only 10 percent of the arrests, while the vast majority were for so-called "nuisance crimes," such as trespassing or disturbing the peace, and offenses related to substance abuse (Swanson et al. 1999).

Clark, Ricketts, and McHugo (1999) studied patterns and costs of criminal justice involvement among people with co-occurring serious mental illness and substance abuse problems. These researchers found that over a three-year period, 83 percent of the sample had some involvement with law enforcement, but only 44 percent were officially arrested. Two-thirds of the arrests were for minor offenses. The study participants were four times more likely to have a police encounter that did not result in arrest than to be arrested and booked for a crime. Many times police were involved as an ersatz ambulance service, transporting patients in a psychiatric crisis to an emergency treatment facility—with the trappings of criminal arrest. (When we look at crime and mental illness in the United States, are we observing the intersection of illness and illegal behavior *per se,* or are we seeing the peculiarities of our own sometimes dysfunctional public systems of care and crime control, and how they are organized and financed?)

Substance abuse is perhaps the most important single factor that distinguishes justice-involved people with mental illness from their counterparts without criminal involvement. Thus, taking stock of substance abuse comorbidity is central both to understanding the scope of the problem of crime and mental illness, and to designing effective policy solutions. But again, people with comorbid substance abuse are a clinically heterogeneous population. There are several alternative pathways by which substance abuse can, in conjunction with mental illness, influence crime. First, mental illness is associated with increased primary risk for substance abuse; this may be due to common heritable or social-environmental risk factors, or it may reflect self-medication for psychic pain. Substance abuse often involves acquiring and possessing illegal substances, but this may or may not precipitate criminal justice involvement.

Several potential causal pathways may link substance use disorders to violence in persons with a serious mental illness such as schizophrenia. First, acute pharmacological effects of alcohol and certain drugs such as cocaine can increase violence risk; this is true in persons with or without serious mental illness. In patients with underlying mental illness, however, pharmacological effects of alcohol and other substances may increase inherent violence risk by exacerbating psychiatric symptoms. Specifically, violence may become much more likely when substance abuse is added to the mix of impaired impulse control and symptoms such as hostility, threat perception, grandiosity, and dysphoria. Substance use disorders are also associated with

treatment nonadherence, which is well-known to elevate the risk for violence in outpatients with serious mental illness.

To sum up, Frank and McGuire have made an important new contribution—both conceptually and empirically—to understanding the ways in which mental health treatment may affect criminal justice outcomes. Going forward, it is important to continue to specify and refine the evidence for effectiveness of policy and interventions to reduce the multilayered problems of crime and mental illness. Outcomes *for whom*? Who are the target populations for *which* interventions? People who commit crimes and people who suffer from mental illnesses represent overlapping and heterogeneous populations. Criminal behavior and mental illness are multidetermined phenomena—to some extent endogenous—but with some common, and some unique exogenous predictors. Our conceptual models and our research inquiries into how these problems emerge and may tumble over each other, as well as our solutions to address them as such—together and separately—need to be equally nuanced and subtle.

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