

Crime & Law

Mental Disorder and Crime (I)

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Many high-profile cases that have appeared on the news were committed by individuals who allegedly suffered some serious mental disorder. In 2007, for example, Seung-Hui Cho shot and killed 32 people on the Virginia Tech university campus before taking his own life. He was previously ordered by a judge to seek outpatient care after making suicidal remarks to his roommates (CNN, 2016). Josef Fritzl, the Austrian man who fathered seven children with his own daughter while keeping her captive in the basement of the family house for 24 years, suffered from a severe personality disorder according to a psychiatric evaluation (The Telegraph, 2008). In 2012, James E. Holmes opened fire on hundreds of unsuspecting moviegoers at the midnight premiere of *The Dark Knight Rises* in Aurora, Colorado. Dressed in body armour, he unleashed tear gas and killed 12 people and wounded 70 other. His defence attorney claimed that Holmes suffered a psychotic episode resulting from schizophrenia, a diagnosis confirmed by 20 doctors (Gurman, 2015).

Cases like these have led the general public to ask questions about the relationship between mental disorder and crime. Does mental disorder cause crime? Can mentally disordered offenders be held guilty for their actions? How should the criminal justice system respond? This two-part series aims to address these questions by critically exploring the extent to which mental disorders contribute to the understanding of crime causation and by analysing their impact on criminal justice practices. To that end, in the first article we will examine the concept of mental disorder from the perspective of both medicine and law. Then, in order to introduce the relationship between mental disorder and crime, we will focus on the overrepresentation of mentally disordered people in the criminal justice system.

Concept of mental disorder: An overview

The concept of “mental disorder” is problematic because it encompasses a large number of human behavioural symptoms and conditions, ranging from common disorders such as anxiety and depression, to more serious psychopathological disturbances like dementia and schizophrenia, as well as substance-use disorders related to drug and alcohol abuse and dependence, and various personality disorders (Helfgott, 2008; Busfield, 2011). However, this is not a closed list, since the overall boundaries of mental disorder have been widened over the last century due, among other reasons, to the construction of new types of disorder (Busfield, 2011). Despite the evident difficulties, there have been many attempts to define mental disorder, both in medical and legal terms.

In medical terms, mental disorders are most commonly defined in relation to the *International Classification of Diseases (ICD)*, produced by the World Health Organisation (WHO), and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association (APA). Both resources contain a categorical classification system of mental disorders and provide mental health professionals the diagnostic tools to identify them (von Berg, 2014). In legal terms, the European Court of Human Rights (ECtHR) has developed the concept of “unsound mind” through its case law on the right to liberty and security laid down in Article 5 of the European Convention of Human Rights (ECHR), which allows “persons of unsound mind” to be deprived of their liberty (ibid.). Both definitions will be further discussed in the following sections.

Medical concept

In 1893, the International Statistical Institute adopted the first international classification system, known as the International List of Causes of Death and ultimately as the ICD. After several revisions, it was entrusted to the WHO at its creation in 1948, which published the 6th revision, ICD-6, the following year (WHO, 2016). For the first time, a separate chapter on mental disorders was included, and subsequent revisions were aimed to further improve and expand it. This effort has been supported, in particular, by the APA, which developed the first edition of the DSM in 1952 based on the ICD-6. Thanks to the collaborative agreements between the WHO and the APA, the two classification systems have become increasingly harmonized. In their current revisions, ICD-10 and DSM-5, they are not entirely homologous, but for the most part they are identical or differ in insignificant ways with regard to the diagnostic categories and criteria (Helfgott, 2008; Quah, 2016).

The ICD-10 recognizes the challenge of conceptualizing mental disorder by introducing its definition under the heading “problems of terminology”:

Disorder is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here (WHO, 1992, p. 11).

The DSM-5, on the other hand, gives following definition:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflect a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g.

political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as describes above (APA, 2013, p.20).

As can be noted, these definitions are very similar. Both systems define mental disorders by associating them with distress or disability. In other words, they are understood to be conditions associated with harm. However, not all conditions associated with harm are to be considered as mental disorders, only those which involve a personal dysfunction. Deviation from social norms alone does not count as mental disorder, neither for the ICD-10 nor the DSM-5. The latter also establishes that the condition cannot simply be an expectable or culturally approved response to a common stressor or loss (Bolton, 2008).

Legal concept

The European Convention of Human Rights was drafted in 1950 by the Council of Europe and came into force in 1953. It was the first comprehensive international treaty for the protection of human rights to emerge after the Second World War and to enforce some of the rights stated in the Universal Declaration of Human Rights of 1948 (Schabas, 2015). Being a product of its time, the ECHR makes only one single reference to people with mental health problems. Article 5(1) provides for the right to liberty and security, but establishes an exception for “the lawful detention [...] of persons of unsound mind”.

The Convention does not explain what is meant by the words “persons of unsound mind”. In the case of *Winterwerp v. the Netherlands*, the Court held that:

This term is not one that can be given a definitive interpretation: [...] it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society’s attitude to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more wide-spread (para. 37).

In the same judgment, the Court also said that:

The very nature of what has to be established before the competent national authority -that is, a true mental disorder- calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder (para. 39).

From this it follows that, in practice, a clinical opinion is required in order to determine whether an individual has a mental disorder or not. This links the legal definition of “unsound mind” with the medical definition of “mental disorder” (von Berg, 2014). Furthermore, this approach is consistent with the Recommendation No. Rec (2004)10 adopted by the Committee of Ministers of the Council of Europe in relation to the protection of the human rights and dignity of persons with mental disorder. It defines persons with mental disorder “in accordance with internationally accepted medical standards”, an example of which, according to the Explanatory Memorandum that accompanies the Recommendation, is the ICD-10 (European Union Agency for Fundamental Rights, 2011).

Mental disorder in the criminal justice system

It has been widely reported that people with mental disorders are highly overrepresented in the criminal justice system compared with their representation in the general population (Lurigio, 2012). In the United Kingdom, for example, were one in four adults experience some form of mental disorder, the Mental Health Foundation estimates that up to 90% of British prisoners have a mental disorder, substance abuse problem, or both. While male prisoners are 14 times more likely to have a mental disorder than men in general, female prisoners are 35 times more likely than women in general (Parker, 2015). This also happens in other Western economies.

A study carried out in the United States in 2014 showed that about 1 in 5 adults aged 18 or older (18.1%, or 43.6 million adults) had suffered a mental disorder in the previous year, and 4.1% (9.8 million adults) were so seriously affected that they were unable to perform one or more major life activities (Centre for Behavioural Health Statistics and Quality, 2015). In the criminal justice system, however, over half of the inmates in state prisons and local jails manifest symptoms of mental disorder. Specifically, the rate is 56% for state prisons inmates, 45% for federal prison inmates and 64% for local jail inmates. For female inmates, the rates are even higher, with 61% of federal female inmates and 73% of state female inmates showing signs of mental disorder (Arnold, 2010). Currently, prisons of the United States hold 10 times more mentally ill people than state hospitals across the country, leading prisons to be seen as “de facto” psychiatric hospitals (Parker, 2015; Mills and Kendall, 2016).

In Canada there is also evidence of this overrepresentation. A study of 2001 found that the prevalence of schizophrenia in the general population was about 0.5%, while the rate in provincial prisons was 1.5% and in federal prisons 2.2% (MacPhail and Verdun-Jones, 2013). Overall, it is estimated that 80-90% of the prison inmates have a diagnosis of mental disorder, with antisocial personality disorder being the most frequent (60-80%). Other research has found a high prevalence of conditions such as fetal alcohol syndrome, developmental disabilities, low IQ, and brain injuries (ibid.).

In New South Wales, which has the largest adult prisoner population in Australia (Australian Bureau of Statistics, 2015), the Corrections Health Service conducted a survey in 2001 to investigate the mental health status of the prisoners (Butler and Allnutt, 2003). The findings of the survey showed that the twelve-month prevalence of “any psychiatric disorder” (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or neurasthenia) was substantially higher in the prison population (74%, of which 72% were males and 86% females) than in the general community (22%). The most recent Inmate Health Survey, conducted in 2009, revealed an increase from 43% in 2001 to 49% in 2009 regarding the proportion of prison inmates who reported having ever received assessment or treatment for an emotional or mental problem. The most common mental health conditions were depression (35% of the sample), anxiety (25%) and drug dependence (21%) disorders (Indig et al., 2010).

According to all studies mentioned above, female prisoners are more likely to suffer mental disorders than male prisoners. Reasons for this include the “multiplicity of disadvantages and damages” (Medlicott, 2007, p. 250) women experience before entering into prison. Almost half of them have suffered from domestic violence, and a third have been sexually abused. The psychological distress caused by such events has been linked to a higher prevalence of self-harming behaviour and suicide (Mills et al., 2013). In addition, women experience the pains of imprisonment more intensely than men due to their role as mothers and primary carers. Worry over home and family cause depression and anxiety, and the situation is further exacerbated by the small number of women’s prisons, as this means that women are more likely to be imprisoned away from their home area (ibid.).

As a conclusion of this first article in the series, we can say without any doubt that there is an evident overrepresentation of mental disorders in prisoners. What does this mean for the

relationship between mental disorder and crime? Could there really be a causal link between them? We cannot give a clear answer at this point, but in our next article we are going to delve more deeply into this issue and examine all the relevant empirical literature.

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Anuncios

Etiquetas: [Criminología](#), [Derecho](#), [Trastornos mentales](#)

Una respuesta a “Mental Disorder and Crime (I)”

1. Pingback: [Mental Disorder and Crime \(II\)](#) |



Crime & Law

Mental Disorder and Crime (II)

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In the [first article](https://crimeandlawblog.com/2017/01/18/mental-disorder-and-crime-i/) of this series, we examined the concept of mental disorder and the overrepresentation of mentally disordered people in correctional populations. The elevated rates of mental disorders in prisoners compared with the general population might imply a causal relationship between mental disorder and crime, so in this article we are going to analyse if there really is a causal link between them with the help of empirical studies. After this we will look into the reaction of the criminal justice system to this issue. The final section will formulate some conclusions.

Relationship between mental disorder and crime

The relationship between mental disorder and crime is an issue of significant empirical complexity. It has been subject of extensive research, using both cross-sectional and longitudinal designs and including samples of the general population, birth cohorts, psychiatric patients, and incarcerated offenders. Nevertheless, findings have been equivocal (Sirotich, 2008).

On the one hand, several studies have found a relationship between mental disorder and crime. Tiihonen et al. (1997) examined the quantitative risk of criminal behaviour associated with specific mental disorders by studying an unselected 1966 birth cohort in Northern Finland until the end of 1992. The results suggest that the risk of criminal behaviour was significantly higher among subjects with mental disorders, regardless of the socioeconomic status of the childhood family. In particular, the higher risk for violent behaviour was associated with alcohol-induced psychoses and with schizophrenia with coexisting substance abuse. Hodgins (1998), who reviewed five epidemiological investigations of post-Second World War birth cohorts, came to the conclusion that persons who develop major mental disorders are at increased risk across the lifespan of committing crimes. However, this increased risk may be limited to generations of persons with

major mental disorders born in the late 1940s, 1950s and 1960s, as they do not have received appropriate mental health care. After examining data from national hospital and crime registers in Sweden covering the period 1988-2000, Fazel and Grann (2006) found that the overall population-attributable risk fraction of patients was 5%, indicating that patients with severe mental disorder commit one in 20 violent crimes. Modestin and Ammann (1995) compared Swiss in-patients with the general population and came to the conclusion that patients were more frequently registered in all crime categories, although there were differences between the diagnostic groups: while alcoholics and drug users of both sexes had a significantly higher criminality rate, a higher rate was found among female, but not male, patients suffering from schizophrenia or related disorders. Finally, a study by Eronen et al. (1996) found that homicidal behaviour appears to have a statistical association with schizophrenia and antisocial personality disorder.

On the other hand, there are also studies that discard any relationship between mental disorder and crime. In a study which examined the ability of personal demographic, criminal history, and clinical variables to predict recidivism in mentally disordered offenders in the United Kingdom, Philips et al. (2005) found that reconviction in mentally disordered offenders can be predicted using the same criminogenic variables that are predictive in offenders without mental disorders. Fulwiler et al. (1997) analysed the relationship between violence and substance abuse among patients with chronic mental disorder and found that major mental disorder alone, with no history of alcohol or drug abuse, was associated with a considerably lower risk of violence. Overall, the study showed no difference in the rate of violence between patients with major mental disorders and patients with other diagnoses. Other studies suggest that the diagnosis of schizophrenia and delusional disorder, contrary to previous empirical findings, do not predict higher rates of violence among recently discharged psychiatric patients (Monahan et al., 2001, pp. 77 and 90). Along the same lines, Lindqvist and Alleback (1990) found that the crime rate among male schizophrenic patients was almost the same as that in the general male population. However, the crime rate among females was twice that of the general female population, so the overall results of the study were mixed.

Alternative explanations for overrepresentation

If the causality link between mental disorder and crime is so hard to establish, what other factors may explain the overrepresentation of mentally disordered people in prisons? One possible explanation could be the “criminalization” of people with mental disorder, meaning that they are being processed through the criminal justice system instead of the mental health system (Lurigio, 2013). The criminalization is blamed on the deinstitutionalization of mental health hospitals in the 1960s and 1970s, which led to the replacement of psychiatric hospitals with community mental health centres. Lacking the necessary mental health resources and treatment options in the community, people with mental disorders ended up in prison as a way to access psychiatric care (Peterson and Heinz, 2016).

Another explanation is that people with mental disorder typically reside in poor neighbourhoods, where they are exposed to the same criminal risk factors as people without mental disorder (e.g., unemployment, gang influences, failed educational systems, and housing instability). Because of their illnesses, mentally disordered people have more difficulties to finish education or maintain a job, which in turn complicates upward social mobility. Living in poverty and with no legitimate opportunities for advancement, people with mental disorders have no other choice than to engage in criminal activity (Lurigio, 2012).

An untreated mental disorder can strain relationships with friends and family, which also constitutes a contributing factor to violence and criminal activity. According to a study by Silver

and Teasdale (2005), the lack of social support has a negative impact on the psychological well-being of the individual, who has fewer resources to cope with stress and vent frustrations, as well as fewer community ties that protect against criminal activity such as church or community groups. In this way, mental disorders can lead to social rejection, which lead to criminal behaviour (Peterson and Heinz, 2016).

Finally, mentally disordered people become involved with the criminal justice system through substance abuse, which makes them more vulnerable to arrest for drug possession (Lurigio, 2012). Studies of patients admitted to public mental hospitals have consistently found high rates (around 50%) of substance use disorders (Lehman et al., 1994). The odds ratio of having some addictive disorder is 2.7 among those with a mental disorder, that is to say nearly three times higher than in the general population (Regier, 1990). In many cases, it is the result from mentally disordered people's attempts to self-medicate with drugs or alcohol in order to alleviate the impact of their untreated psychiatric symptoms or to relieve the debilitating side effects of antipsychotic medications (Lurigio, 2012).

Response of the criminal justice system

If there really was a causal relationship between mental disorder and crime, the logical consequence is to treat the mental disorder and to absolve the offender of criminal responsibility. However, there is no sufficient empirical evidence to establish unequivocally the existence of such a relationship, making the issue of what consequences should rightly follow much more complicated. Mental disorder and offending behaviour can coexist within the same person without there being any correlation between the two (Peay, 2010).

In order to determine whether a mentally disordered offender should be sent to a psychiatric hospital or to prison, he is examined to assess if he meets the law's rationality standard in the context in question. This requires him to prove either that he did not know the nature and quality of the act he was doing, or that he did not know that what he was doing was wrong. Offenders who satisfy these criteria are neither criminally responsible nor competent to stand trial because they are not rational (Morse, 2011).

What happens to those mentally disordered offenders who, having been declared mentally fit to face charges, end up in prison? According to some studies, longer periods of incarceration may lead to more mental health symptoms. If they are left untreated, the offender may display an increasing disruptive, noncompliant, and aggressive behaviour in reaction to the stressful life in prison (Simpson et al., 2013). This misbehaviour can result in solitary confinement, which has been found to exacerbate symptoms of mental disorder (Fazel and Baillargeon, 2011). Furthermore, it prevents them from participating in programs that would earn them good-time credits, thus limiting their options for early release (Lurigio, 2001).

Despite the availability of mental health services in prison, many inmates remain reluctant to access them for several reasons: a) self-preservation concerns, which include issues of confidentiality and negative perceptions from other inmates (seen as weak or a snitch); b) procedural concerns, that is, a lack of knowing how, when, and why to access services and anticipated length of services; c) self-reliance, which refers to a reliance on themselves or close others for help; and d) professional service provider concerns, which relate to questions of staff qualifications and dissatisfaction with previous mental health services (Morgan, 2007). In the case of inmates with suicidal tendencies, studies have found that they may intentionally hide their mental state to avoid restrictions on allowable possessions, close monitoring of their behaviour, worse housing status, and perceptions of weakness from other inmates (Bauer et al., 2010).

The most effective criminal justice response to mental disorder includes comprehensive rehabilitative programmes that adhere to the risk-need-responsivity principles (ibid.). According to the risk principle, rehabilitative services are more effective when they match offender's level of risk for criminal recidivism. The need principle dictates that these services must target the specific risks associated with criminal recidivism (for example peer associations, substance use, and work or school functioning). Finally, the principle of responsivity asserts that rehabilitative services should match offender's needs and learning styles. Programmes that include all three principles address the holistic needs of mentally disordered people, rather than just focusing on mental health symptoms and treatment (Peterson and Heinz, 2016). Studies have demonstrated that they reduce criminal recidivism in 30%, whereas sanctions alone (incarceration without rehabilitative services) and inappropriate rehabilitative services (services that only target the underlying mental disorders) increase it (Bauer et al., 2010).

Conclusion

Prison inmates have high rates of mental disorders compared with the general population. While this may imply a causal relationship between mental disorder and crime, disparate research results do not allow for such a conclusion to be drawn. However, mental disorders are intertwined with several risk factors for criminal activity, such as poverty, unemployment, lack of social support and substance abuse. It is important to point out that these factors also affect the population without a mental disorder, which further weakens the link between mental disorder and crime. Nonetheless, mentally disordered offenders still require treatment for their own mental well-being, but treatment alone cannot be expected to reduce recidivism and criminality. The most effective rehabilitative programmes in terms of improving criminal justice outcomes are those which address the whole social context of the offenders as well as their clinical symptoms.

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Anuncios

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