MENTAL ILLNESS OR CRIMINAL THINKING, IS CRIMINALIZATION TRUTH OR FALLACY?

Psychosis has a certain "signature". Someone who has never been exposed to serious mental illness may confuse psychotic symptoms with criminality. It can be frustrating to someone who recognizes psychotic utterings as signs of serious illness when others interpret these symptoms as a type of criminal thinking. The general public mostly gets exposure to "psychosis-speak" from media accounts in coverage of high-profile incidents of violence, criminal proceedings, and unfortunately, inaccurate depictions of SMI on television. People who are in abnormal states of consciousness or who have cognitive impairments of certain kinds tend to express themselves with unguarded matter-of-factness, – which unfortunately, is taken at face value as incriminating. Interestingly, people are sometimes unguarded in expression of criminal thinking, which may suggest diminished intellect or something about brain function that is neural-atypical:

Criminal Thinking	**Psychotic Thinking**
If someone disrespects me they deserve to get whatever they have coming to them.	I saw demons enter the hearts of the children, so I killed them to save their souls.
It's different if you steal from a rich person instead of a poor person. They got rich from keeping people down.	I am Jesus Christ. I made the eternal flame to consume the unbelievers.
The law isn't fair. You have to take matters into your own hands.	The FBI implanted thoughts in my child. God told me to destroy the child to remove the impure thoughts.

Note: The syntax of the statements representing psychotic thinking is enhanced as an aid to show the linkage between thought and violent action. There is typically a breakdown in certain elements of expression that join clauses or relate ideas and thoughts (such as 'so, I killed'.....'made, *to* consume')

There have been studies done to look at why there is such a high percentage of people with SMI in prisons and jails. The socio-political contexts in which mass incarceration of people with SMI exists cannot be ignored.

- There is heightened awareness of mass incarceration of people who have SMI.
- There has been an emergence of diversion, intercept, and individual justice models that seek to keep the mentally ill out of jails and prisons.

- Sheriffs and Wardens of jails across the country, who are taxed with the challenges of managing mentally ill inmates, have emerged as some of the most lucid and reasonable proponents of diversion.
- There has been condemnation of the "prison industrial complex" broadly, and of the private prison industry for its particular facet of the problem.

There are going to be antagonists who are looking for evidence to justify some of the actions of government and the criminal justice system that advocates are blaming for mass incarceration of the mentally ill. Applying criminal penalties to actions caused by SMI is what defines Criminalization. Some of the stakeholders in a regime of mass incarceration of the mentally ill might be trying to make the case for why the mentally ill belong right where they are, in jail and prison.

Some professed advocates (the anti-stigma activists) for the mentally ill have been criticized on this site for throwing the mentally ill under the bus once they are charged with serious crimes, so they too have a stake in finding innate criminality in offenders . Others are attempting to take a hard look at mass incarceration of the mentally ill in a less presumptive way, objectively proposing that there may be complex factors that lead someone into engagement with the criminal justice system.

DJP is critical of lawmakers and the criminal justice system for operating on the basis of retribution over reason and understanding. If medical science, facts, or reason get in the way of retribution, then those moderators are too often shunned and extricated from due process. Cognitive biases are also a risk of vigorous advocacy, so there is a need to be open-minded when researching controversial issues.

Inquiry into the topic of criminal thinking and mental illness led to the finding of some research papers that propose that there are many complex factors that are involved that drive people into the criminal justice system. It cannot be denied that criminal thinking, psychological, cultural, or intellectual capabilities of a person as pre-morbid functioning are going to become fodder for psychosis. It is reasonable and sensible to conduct these types of studies as long as the mindsets conducting them are not biased. The following is a fairly balanced report:

https://www.sciencedaily.com/releases/2014/10/141014123716.htm

However, looking at the content of some reports, one might question who is funding some of these studies and why. There are numerous other material questions to be asked about the modeling of these studies. The presence of other societal factors must be kept in scope when evaluating the integrity of these studies in terms of who gets criminalized and who gets treatment in the community. People with SMI who come from communities where there is a high instance of culturally-induced criminal thinking may be overrepresented in study groups. It is likely that someone who is both mentally ill and living in volatile community with high crime rates and lack of access to healthcare has a much higher risk for criminalization – and some studies acknowledge this. Some people who might otherwise have become convicted and imprisoned are living in culturally healthy communities with much better access to medical care and supportive services – or, in community-based institutions where they have supported care and monitoring to keep them out of trouble.

Many of these studies are concluding that criminal thinking rather than SMI is the critical factor that led to engagement with the criminal justice system and that mental illness had little or nothing to do with their crimes.

http://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1022&context=mhlr

Note this commentary on pdf pages 14-15 from the link above:

"However, there is little empirical evidence showing that the criminalization hypothesis adequately explains the overrepresentation of people with mental illness in jails and prisons. One study of psychiatric hospitals and prisons between 1969 and 1978 did not find that the prevalence of mental illness in prisons increased during this time frame. In fact, in three states there was more mental illness in prisons in 1969 than in 1978."

In reference this this report, the conclusion that SMI is not a significant factor and that "criminalization" is not legitimate to the extent charged is subject to reasonable skepticism, based on the scant references cited. DJP also suspects that people who committed the most serious offenses in the community before mass deinstitutionalization were never in hospitals in the first place because the general public and criminal justice system did not understand SMI then any more then than they do now. (note: in commentary to follow, DJP suggests that these findings could result from aggregation and smoothing of data across the states)

Note this commentary on pdf page 16 from the link above:

Stress exacerbates mental health symptoms, and the stress of being in prison is certainly no exception. A study of over 16,000 federal and state inmates found that offenders experiencing psychosis and major depression were more likely to receive infractions involving aggression while incarcerated.

Here, there is the insertion of an intervening "rationalized" factor of stress as being the cause of misconduct. The particular symptoms of SMI, such as cognitive impairments, consciousness disorder that neurologically disconnects people from the reality of their environments, disorientation, sensory processing disturbances that cause difficulty in understanding commands and following rules are either not understood or are not recognized. It could be that the researchers (or the sources they are citing) are applying an intuitive presumption of how mental illness leads to disturbances in behavior.

Note this commentary on pdf page 16 from the link above:

Another theory that has gained support in recent years is based on the idea that offenders with mental illness are not very different from offenders without mental illness when it comes to criminal risk factors.

This notion is addressed previously. Also, the question is whether psychosis is dominant over all other factors, without the insertion of intervening rationalizing factors (such as stress), and Due Justice Project believes that is certainly the case, especially as symptoms become more acute.

Note this commentary on page 16 from the link above:

Unfortunately, there is little evidence that interventions that focus solely on treating symptoms are effective at reducing recidivism for offenders with mental illness.

...And the advocate might respond to this finding with the retort "Tell us something we don't already know". It stands to reason that people with SMI will cycle back into incarceration if only treatment of symptoms is what is proposed to reduce "recidivism". There are caregivers and advocates across this country who are trying to get legislators and policy makers to understand that placing someone "in the community" (which means at home with family or stashed in an apartment alone with promises of support) with access to community treatment centers, or even AOT is insufficient. Some people are too ill to be cared for by families or to be living in supportive vs supported settings. Society does not understand that appropriate housing is the preeminent requirement before treatment. Some people need 24 hour monitoring and support with medication adherence from trained staff, oftentimes in restrictive settings up to and including locked units.

Another factor is that these types of long term residential facilities are believed to be needed for people who have serious "negative" symptoms (such as significant disorganization which makes meeting nutritional or other personal care needs very difficult) and the facilities may only be transitional. This concept does not reconcile with the fact that many higher functioning people need supported care as well. Someone who can cook for themselves and tend to their own personal care needs, but suffers from anosognosia and is delusions can be just as much at risk as someone with "negative" symptoms. Ironically, in many cases, CRRs or LTSRs are only transitional and used to conduct people from incarceration back into the community. Someone can only reside in the facility only temporarily while they are coached in life-sustaining skills to prepare them to return to the community, where they are once again at risk. These types of facilities are needed for a subgroup of people with SMI as an integral part of community-based care, not just to serve inmate populations. So this finding in a study is looking at a statistic but drawing a conclusion that is supportive of a certain thesis. (note that this is substantively why DJP, under position statements, rejects the terminology "recidivism" where applied to people with SMI).

Aside from that, there are some notable legislative and policy changes prior to, after, and along this timeline cited on pdf page 14. There are also studies that reach other conclusions, and broad problem scope analyses of deinstitutionalization's failures (which includes the consequence of re-institutionalization in jails and prisons.).

http://journalofethics.ama-assn.org/2013/10/mhst1-1310.html

http://scholarship.claremont.edu/cgi/viewcontent.cgi?article=1348&context=cmc_theses

1965 – Passage of Medicaid incentivized trans-institutionalization into nursing homes and general hospitals because of the exclusion for institutions for mental diseases. (which at least kept the most impaired people institutionalized in nursing homes – a condition that the United State Justice Department is suing states for even at present, again, because they do not understand SMI and have been led astray by disability rights activists)

1967 Passage of the Lanterman-Petris-Short Act in California which made involuntary hospitalization much more difficult. A media account reports that one year after passage, the number of mentally ill people in the criminal-justice system doubled – which calls into question the claim that there was no increase in the prison populations of people with SMI. This suggests aggregation and/or smoothing of data across state-level statistics.

1980 – Passage of Mental Health Systems Act – aimed to improve services in the community.

1981 – The Mental Health Systems Act was repealed in favor of block grants. Spending by the Feds drops 30 percent.

The Olympian (Washington), October 9, 2003.

According to the U.S. Department of Justice, 40 mental health hospitals have closed in the past decade. During the same period, 400 new prisons have opened.

**To be objective, the war on drugs, and more aggressive sentencing probably factor into the increase in new prisons, but those forces would also draft an increased number of mentally ill persons into the system.*

http://content.healthaffairs.org/content/28/3/676.full

An increase in admissions to state hospital forensic units for competency restoration is first noted at the end of the 1970s. Since the increased admission rate of this patient group was first noted at the end of the 1970s, the percentage of people committed via this route, rather than through civil commitment, has continued to grow. For example, between 1988 and 2008, the proportion of Vermont state hospital admissions accounted for by forensic patients increased 50 percent; in Massachusetts, 281 percent; in New York, 309 percent; and in Pennsylvania, 379 percent.

**Note: It is unknown what role that the Drusky and Sell cases had in these statistics*

Keeping in mind that people with the most serious types of mental illness, with first-rank symptoms of psychosis, are a very small percentage of the overall population, one should not expect to see a disproportionate representation of people with SMI incarcerated unless SMI can be equated with criminality. If there is overrepresentation without this linkage, then the outcry against criminalization cannot be delegitimized. Also, in the most serious violent crimes where psychosis is involved, Due Justice Project believes that **psychosis is the commanding factor** – it deprives a person of the mental faculties that are needed to mediate criminal thinking....while it produces grossly disordered thinking of its own.

Another study linking engagement with the criminal justice system to criminal thinking:

http://www.apa.org/news/press/releases/2014/04/mental-illness-crime.aspx

Excerpt: A crime could be rated as mostly unrelated or mostly related to mental illness symptoms if those symptoms contributed to the cause of the crime but weren't solely responsible for it. For example, an offender with schizophrenia who was agitated because he heard voices earlier in the day later got into a bar fight, but he wasn't hearing voices at the time of the altercation, so the crime was categorized as mostly related.

It would be interesting to see full transcripts of the interviews to look for how the questions were structured, worded, and answered. It would also be of interest to know what the state of wellness was for the subjects in the study. In the linked to study referenced above, the competency of the research team is also questionable.

For example, note the way that the researcher/other construed the cause and effect relationship between auditory hallucinations and a criminal act. Again, there is an intervening element inserted that "rationalizes" and thereby criminalizes the unlawful behavior. People who do not understand psychosis have to process the behaviors of the mentally ill through the context of mindsets that they can conceptualize or relate to, that is why literature on SMI often states that serious mental illness is poorly understood by most people. Here, a single symptom is isolated, then converted into an (intervening) emotion (anger/agitation), which in turn becomes the "rationalized" driver for assaultive behavior. This construct resembles a lay person's conceptualization of how voices might propel someone toward an assaultive act. The clinical notes in a particular case might shed some light on the symptom complex that was afflicting a person at the time of an assaultive act, but even the clinical notes might not have integrity if the accused was sitting in jail for months awaiting a competency evaluation.

Excerpt: Some participants may have described their mood as "manic" during a crime even though they could have just been angry or abusing drugs or alcohol, so the percentage of crimes attributed to bipolar disorder may be inflated.

This type of sloppy presumption might have resulted in a large-scale discharge of blame to "other causes". Again, the clinical records would be complimentary to a self-report . Comprehensive, well-designed studies do analyze these records, so it is odd that odd that the "findings" have such a casual speculative quality.

Other papers on the topic of criminal thinking alone, i.e. not in the context of mental illness, lead to the formation of some unexpected impressions. The orthodox definitions and characterizations of criminal thinking are products of social sciences. Some of the resources were rife with highly politicized characterizations of certain mindsets. For example, in several papers, there were representative responses to questionnaires that looked more like fabrications (maybe they were, maybe they were not). In each case, there is a condemnatory remark that discounts the possibility that victimization is legitimate cause for complaint (such as abuse by authorities or family members, or institutions). Some of the commentary seems to exempt authorities from all responsibility for their own antisocial

behaviors. Even though victimization is not an excuse for criminality, when this kind of bias is seen, then the motivation of whoever funded the study is subject to skepticism.

The takeaway from researching this topic is that there are forces out there that are trying to delegitimize the notion of criminalization. There is validity to the assessment that there are often complex factors that lead to incarceration of people with a SMI diagnosis. However, advocates know that criminalization is a legitimate issue, that it is a very serious problem, and it is without question an injustice.