Mental illness, Crime, and Violence: 
Risk, Context, and Social Control

Fred E. Markowitz
Department of Sociology
Northern Illinois University

In this presentation, I address the following issues:
• How has the nature of mental health care changed in such a way that has led to more people with mental illness in jails and prisons than in hospitals?
• What are the pathways by which persons with mental illness end up there?
• Public perception of violence among the mentally ill
• Objective assessments of the risk
• Efforts at addressing the problem of mental illness in the criminal justice system

Deinstitutionalization, mental illness, and the criminal justice system

According to NIMH estimates:
• In 1960, about 563,000 beds were available in U.S. state and county psychiatric hospitals (314 beds per 100,000 persons), with about 535,400 resident patients.
• By 1990, the number of beds declined to about 98,800 (40 per 100,000) and the number of residents to 92,059.
• By 2005, there were only 17 public psychiatric beds available per 100,000 persons, despite increases in the population and estimates that about 50 beds per 100,000 are needed for minimal treatment capacity.

Also:
• In the early 1960s the average length of stay was about 6 months.
• By the early 1990s it had declined to about 15 days.
• By 2007, it was less than 10 days.
• Meanwhile, the rate of admissions from the early to mid 2000s has increased slightly

Factors contributing to the drop in inpatient capacity:
• Medications developed that controlled the symptoms of the most debilitating mental disorders (e.g., schizophrenia).
• Ideological shift, advocating a more liberal position on confinement led to states adopting stricter legal standards for involuntary commitment (dangerousness to self or others) that are not frequently used.
• Perhaps most important, shifting of costs for mental health care from states to the federal government (Medicare, Medicaid, Social Security Disability Income), followed by budget cuts and substantial underfunding of community mental health services.
Consequences of Deinstitutionalization

• Most treatment takes place in outpatient settings, many patients do well
• However, many lack “insight” into their disorders, go untreated, or have difficulty complying with medication regimens, and are unable to support themselves
• Those with the most severe disorders still require hospitalization
• Patients often stabilized (e.g., given medication) and released

Without adequate follow-up and community treatment support programs:

• Not surprisingly, substantial numbers of these patients end up being readmitted (“revolving door”) phenomenon
• Increase in the portion of homeless persons with mental illness (estimated 1/3 to 3/4 of homeless persons have a mental illness)

Consequences for the criminal justice system

• Increase in the portion of persons in jails and prisons with mental illness
• Estimated 16-25% of persons in jails and prisons have a serious mental illness
• The most recent study puts the estimate of the percentage inmates with a history of mental health problems in jails at 64% and at 56% for state prison inmates, with 50-60% reporting current symptoms
• It is estimated that there are now more than three times as many persons with mental illness in jails and prisons than in psychiatric hospitals
• These inmates are less likely than others to be released on bail, more likely to experience abuse from guards and other inmates, and are at an increased risk of suicide
• Homelessness is an important pathway to incarceration among the mentally ill

Violence and mental illness

Studies of Public Perception

• A high percentage of the general public associates psychotic disorders and substance abuse with violence

How dangerous are persons with mental illness?

• The best studies find an increased risk of violence among persons with mental illness (e.g., one-year incidence of about 25% vs. 2% among non-mentally ill)
• Also, increased risk of being the victims of violence
• The risk is on par with other social-demographic variables (age, SES, race)
• Higher incidence of violence/arrest attributed to certain untreated psychotic symptoms, illness, externalized depression, “conflicted” social relationships
• The risk is elevated when there is also substance abuse and persons are living in “socially disorganized” neighborhoods (low income, residential instability, fragmented families)
• Also, much of the violence occurs among persons who know each other

Police encounters with persons with mental illness

• Police among those most likely to deal with persons with mental illness in crisis situations
• One of the main sources of referral of persons into mental health treatment
• Sometimes use “mercy bookings”
• See troublesome situations through role as “law enforcers,” motivated to maintain authority in conflict situations, often invoking the power of arrest to do so
• Study of police-citizen encounters showed that whether suspects are under the influence of drugs, are noncompliant, fight with officers or others, as well as the seriousness of their offense predicts the likelihood of arrest among persons with mental illness

Public policy responses

Community treatment alternatives:

• Intensive case management
• Jail diversion programs
• Mental health courts
• Legally mandated assisted outpatient treatment
• Crisis intervention training for police

Limited effectiveness in terms of symptom improvement, quality of life, and likelihood of re-offending (Public safety vs. public health)

Programs are most effective when they address issues required to facilitate recovery from mental illness more generally, including illness management, employment, housing, substance abuse

Conclusions

• In the absence of public psychiatric hospital capacity, many persons with mental illness fall through the cracks of community-based services, which can be effective, but are often fragmented and require active engagement on the part of persons who require them, yet may not recognize the need to do so.
• Unfortunately, this leads to an increased risk of homelessness and involvement in the criminal justice system, as well as stigmatization. The problem is especially pronounced among those who are economically disadvantaged, who are more likely to reside in “disorganized” neighborhoods, where stress and cultural differences in dispute resolution enhance the risk of crime.
• Despite an apparent improvement in public understanding the nature and causes of mental illness, mental disorders (particularly psychosis) are linked with perceptions of violence. As such, public’s perceptions are not entirely out of line with objective assessments of risk.
• Unfortunately, perceptions of violence are a significant component to the stigma associated with mental illness which likely adds to the devaluation and discrimination that many persons who are diagnosed—yet are not violent—experience.
Conclusions

• Stigma and social rejection, in turn, limits social opportunities, such as jobs, housing, and social networks for persons with mental illness, that to some extent, serve as protective factors in reducing stress, and thereby reducing the risk of violence.

• While the proportion of persons with mental illness who are at risk of violence/criminal behavior is modest, in the aggregate, the risk translates into appreciable increases in the numbers of persons with mental illness who end up in the criminal justice system—a system that was not intended for therapeutic purposes, but has been forced to adapt by becoming the nation’s largest residential facility for the mentally ill.

• High-quality, well-coordinated community mental health services that focus on both symptom reduction and social economic well-being (e.g., housing, employment) may reduce the number of mentally ill persons who end up in jails and prisons.

• Such efforts require tremendous initiative on the part of policy makers and local agencies, and are likely to be limited in their effectiveness relative to the scale of the problem.