

# **‘Mental Disorder and Crime: Some Unresolved Questions’**

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# Managing Risk and Reintegration

- Can we tell who is dangerous, can we really assess risk and can we manage their reintegration into communities?
- Are those with mental illness properly identified and then managed appropriately?

# Questions

- Do mental disorder and dangerousness intersect to a degree that deserves a focus beyond, for example, dangerousness and drug and alcohol abuse?
- What evidence?
- In what ways might mental disorder underpin dangerous offending?

# Unresolved (and unresolvable?) questions

- Are dischargable patient-offenders more (or less) dangerous than released offenders?
- Does mental illness act as a risk factor or a protective factor for serious offending; and does the answer depend as much on conventional factors underpinning offending as on any unique contribution made by the mental disorder?

# Harper 1991

“Let me be quite clear about this. Statistics is not tables or numbers, sets of techniques, lists of formulae, but is an approach to understanding the world about us. However, that world is very complex and there is no quick and easy way of gaining such understanding..... If everything appears simple and crystal clear probably you have misunderstood the issue you are considering.”  
(from Maguire, Morgan and Reiner 2007)

# Problems with reconviction data

- Need not elaborate here BUT just note that restricted patients are relatively intensively supervised so data on their re-offending likely to be among the best available....

Restricted patients: “....necessary for the protection of the public from serious harm”: a risk – high harm

- Home Office (now Ministry of Justice) annual statistical bulletin ***‘Statistics of Mentally Disordered Offenders’***. Bulletins: 1985 – 2010
- Home Office statistical bulletin ***‘Restricted Patients – reconvictions and recalls by the end of 1995: England and Wales’*** (29 January 1997) Chris Kershaw, Pat Dowdeswell and Joanne Goodman Issue 1/97

# Definitions

**'Grave' offences** are defined as all indictable-only offences for which the maximum sentence is life imprisonment plus arson not endangering life (which is triable either way). The main 'grave' offences are homicide, serious wounding, rape, buggery, robbery, aggravated burglary and arson.

**The category of 'sexual or violent' offences** is defined in Appendix 5 of The Criminal Statistics. They include homicide, endangering life, robbery, kidnapping, child abduction, cruelty or neglect of children, abandoning child, concealment of birth, buggery, rape, indecent assault, incest, procuration, abduction, bigamy, and gross indecency with children.

# Restricted patients: 1999-2006 totals first discharged: % reconvictions

Discharge by **Tribunal** and matched on PNC  
1,159 (1% grave) (7% all)

Discharge by **SS** and matched on PNC  
172 (0% grave) (4% all)

1984 -2008 the % of patients cd by the tribunal, out of a total discharged by either the tribunal or the SS, ranged from 56% to 90% (tribunals cd 4,214 patients and the SS 1,141)

# Problems

- Cherry picking?
- Discharge from SH or 'other' hospitals
- Effect of proportions of pd and mi
- Recalls – the 'not at risk' population
- Criteria for release: comparability MHRT with SS and threshold applied (Tessa Boyd-Caine (2010) *Protecting the Public: Detention and Release of Mentally Disordered Offenders*)
- Cautious strategy makes learning from practice problematic

## 2 year reconviction rates: violence and sexual offences

	Matched	R	%R	E%R	A-E%R
<b>1985-89</b>	503	21	4	11	-7
<b>1989-93</b>	549	14	3	11	-8
<b>1993-97</b>	582	14	2	11	-9
<b>96-2000</b>	600	11	2	11	-9

1999-2006, 1331 discharges matched on PNC: 7% reconvicted within 2 years (2% for violent/sexual offences, 1% grave offences)

# Problems and Questions

- Change from Offenders Index to PNC – formula for prediction on PNC not available so comparative data for expected rates no longer published
- Comparability (matched on criminal history and demographic factors)
- ? Spotting ‘good risks’; effects of supervision; treatment-effected change; tribunals more or as cautious as SS given different cohorts?

# MoJ compendium: any offence on PNC

(all custodial offences and some additional recordable offences)

- Between 1999 and 2007, 5.8 per cent of restricted patients discharged from psychiatric hospitals were reconvicted **within two years** of discharge
- In 2008, 9 per cent of adult first time entrants to cjs reoffended **within twelve months** (excluding those who received a custodial sentence). Since 2006, the proven reoffending rate the rate for adults has been relatively stable during this period.

## **Compendium of reoffending statistics and analysis**

Ministry of Justice: Statistics bulletin 4 Nov 2010

**Mental health: No clinical diagnosis of mental health was made of any of the respondents for the purposes of this study. However, the prisoners were asked a number of questions which could indicate the presence of mental health problems. Prisoners self-reported a number of mental health issues before custody, but these were not necessarily associated with a higher rate of reconviction on release from prison. (p.127)**

**Table 4: Proportion of sample reporting mental health issues  
(based on 1,435 prisoners) MoJ Compendium Nov 2010**

- **Said they needed help for an emotional or mental health problem at the time of interview: 20%**
- **Treated/counselled for a mental health or emotional problem in the year before custody: 17%**
- **Suicidal thoughts in the year before custody: 16%**
- **Mental health illness or depression as a long-standing limiting illness: 12%**
- **Attempted suicide in the year before custody: 9%**
- **Heard voices saying “quite a few words or sentences” when there was no-one around to account for it: 9%**
- **Self-harmed in the year before custody: 6%**
- **Prescribed anti-psychotic medication in year before custody: 2%**

# Compendium of reoffending statistics and analysis

Ministry of Justice: Statistics bulletin 4 Nov 2010

**Mental health: 17% of offenders reported having been treated/ counselled for a mental health or emotional problem in the year before custody. Offenders in this category had a similar reconviction rate (54 per cent) to those who did not (52 per cent). (p.6 )**

# Questions

So, we used to think we knew that discharge from hospital of restricted patients was more successful than matched discharge from prisons; in effect, hospital did better than prison. We don't know it any more. Ought we to know it? Is it just too difficult to compare?

# Are mental disorder and crime related?

- **Question usually posed:** Are people with mental illness more likely to engage in violent behaviour? Which psychiatric illnesses are associated with violence; what is the magnitude of the increase in risk?
- **Context to be remembered:** Most people who are violent are not mentally ill: most people who are mentally ill are not violent
- **Context:** law, media, professional and academic selective perception (see also Mitchell and Roberts 2010)
- The forensic clinician vs the ivory towered legal academic

# Mental Health and Crime?

Given that the causes of crime are complex and multi-factorial.....

- What additional contribution does mental disorder make to the likelihood of offending behaviour?
- Is it primarily a protective factor – reducing the likelihood of offending – or a stimulus to offending?

Graham Thornicroft (2006:139)

*Shunned*

“Whether or not there is any additional risk depends upon the type of diagnosis, the nature and severity of the symptoms present, whether the person is receiving treatment and care, if there is a past history of violence by the individual, the co-occurrence of antisocial personality disorder and substance misuse and the social, economic and cultural context in which an individual lives”.

**Fazel and Grann (2006) The Population Impact of Severe Mental Illness on Violent Crime. *American Journal of Psychiatry* 163: 1397-1403**

- Based in Sweden (high quality national registers)
- Over a 13 year period there were 45 violent crimes committed per 1,000 inhabitants
- Of which, 2.4 were attributable to those with severe mental illness (population attributable risk of 5.2%: ie patients with severe mi commit 1 in 20 violent crimes); or put another way: one violent crime per 1,000 inhabitants every 5 years could be attributable to patients with severe mental illness or violent crime would have been reduced by 5.2% if all those with severe mi had been institutionalised indefinitely

**Fazel and Grann (2006) The Population Impact of Severe Mental Illness on Violent Crime. *American Journal of Psychiatry* 163: 1397-1403**

- Women patients over 40: 19% population attributable risk
- Women patients 25-39: 14%
- Women patients 15-24: 2.9%
- Male patients 15-24: 2.3%

NOTE: pt groups included those with co-morbid diagnoses such as substance abuse – and assumes causality...DOES NOT estimate the unique contribution of psychotic symptoms to violent crime

Previous research: the risk of an individual with psychosis committing a violent offense compared with same age general pop is 2-6x for men and 2-8x for women

# Psychosis and Violence: MacArthur studies

- chronic schizophrenia entails fewer opportunities for violence: violence needs initiative, organisation, social contact and psychomotor activation: severely ill patients have 'less desire and fewer opportunities to engage in the interpersonal interactions that can lead to violence compared with less severely ill patients' (Appelbaum et al 2000:571)

# Mental disorder as a protective factor

Swanson et al (2006: 496): 56 site involving 1,410 patients suffering from schizophrenia:

‘high negative psychotic symptoms were significantly associated with **reduced risk of serious violence**, and that they moderated the effect of the positive symptoms: **violence was significantly** increased by positive symptoms, but only when negative symptoms [social withdrawal, passivity, negativity] were low’

Families can be protective factor and a provocative one: patients living alone less likely to engage in violence than those living with families

## Table 1: Major Violence Risk Factors

### **Prior arrests**

Seriousness  
Frequency

### **Demographic**

Age (-)  
Male  
Unemployed

### **Child abuse**

Seriousness  
Frequency

### **Diagnosis**

Antisocial PD  
Schizophrenia (-)

### **Father**

Used drugs  
Home until 15 (-)

### **Other Clinical**

Substance Abuse  
Anger control  
Violent fantasies  
Loss of consciousness  
Involuntary status

# Silver 2006:689

- ‘no clear understanding of the causal mechanisms that produce the associations between mental disorder and violence currently exists’

Need...

- ‘an embedded individual level approach focussed on a range of theoretically and empirically valid risk factors that may increase the likelihood of violence either in conjunction with or independent of mental disorder and its treatment’

## Monahan (2007:144)

John Monahan, who led the major MacArthur Violence Risk Assessment study in the US, notes mental health status as making **'at best a trivial contribution to the overall level of violence in society'**

# So why focus on mental disorder?

- Higher aspirations for effective intervention (and some evidence to support via limited reconviction data)
- Public perceptions of fear-need-merit?
- ? Asking the wrong questions

a GlassHouse book  
contemporary issues in public policy



# MENTAL HEALTH AND CRIME

Jill Peay



