

CRIMINALIZATION AND NORMALIZATION: SOME THOUGHTS ABOUT OFFENDERS WITH SERIOUS MENTAL ILLNESS

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A great many people caught up in the criminal legal system have mental illness or other mental disabilities. Inmates in jails and prisons in the United States suffer from serious mental illness—defined as schizophrenia, bipolar disorder, or major depressive disorder—at two to three times the rate found in the population generally.¹ In response, many jurisdictions have adopted specialized programs designed to reduce reoffending through the provision of mental health treatment services.² These interventions, including mental health courts, specialized probation and parole programs, reentry programs and the like, all take as given that serious mental illness either causes criminal conduct or places individuals at risk of arrest and seek to prevent such reoffending by providing treatment designed to interrupt or ameliorate an underlying mental disability.³ This intuition regarding causation, and these allied specialized programs, are the target of Professor E. Lea Johnston’s recent article, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*.⁴ Professor Johnston’s careful analysis systematically unpacks the premises that ground this understanding, which she terms the “criminalization” theory, and demonstrates that they are “often unverified and sometimes false.”⁵ Professor Johnston then offers an alternative account, the “normalization” theory, which explains that serious mental illness does not play a direct causal role in most instances of criminal conduct and emphasizes that offenders with mental illness and other mental disabilities become at risk for criminal system

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1. Jennifer L. Skeem et al., *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 110 (2011) [hereinafter *Correctional Policy*]; see Nahama Broner et al., *Effects of Diversion on Adults with Co-Occurring Mental Illness and Substance Use: Outcomes from a National Multi-Site Study*, 22 BEHAV. SCIS. & L. 519, 520 (2004); see also DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEPT. OF JUST., BUREAU OF JUST. STAT., MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1, 3 (2006) (comparing mental health disorder statistics between the general population and local, state, and federal jail and prison inmates).

2. See *Correctional Policy*, supra note 1, at 111.

3. See *id.* at 111–12.

4. E. Lea Johnston, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*, 71 FLA. L. REV. 515, 521 (2019).

5. *Id.* at 515.

involvement for many of the same reasons as other offenders.⁶

Professor Johnston argues that adhering to the criminalization model produces significant negative consequences.⁷ First, it reinforces harmful stigma by depicting individuals with mental illness as especially prone to criminality, violence, or both.⁸ In addition, it supports interventions that draw limited resources that could be directed more usefully to addressing other needs of offenders that demonstrably do cause criminal conduct.⁹ To be sure, the normalization theory acknowledges that serious mental illness often leads individuals to accumulate more, and more intense, risk factors of the sort that contribute to criminal system involvement,¹⁰ but Professor Johnston's conclusion is that rehabilitative interventions should focus primarily on those "criminogenic risk factors" rather than the clinical or treatment needs of offenders with severe mental illness.¹¹

While Professor Johnston is persuasive that clinical factors such as diagnosis and treatment history are not, in most cases, predictive by themselves of criminal behavior, her concession that those clinical factors are associated with a constellation of risks and needs that are predictive of criminal system involvement complicates her efforts to maintain a clear boundary between the criminalization theory and the normalization thesis. Indeed, Professor Johnston's article contains a brief section in which she identifies "possible justifications" for the specialized programs that are the target of her critique.¹² These justifications deserve more attention, precisely because they suggest that the normalization thesis, while powerful, may not entirely displace the criminalization theory upon which those specialized programs rest. Moreover, even if the criminalization theory and the normalization theory are at least partially reconcilable, important questions remain regarding the proper allocation of limited resources both within the criminal legal system and the public mental health system. These questions, in turn, press focus on additional questions with respect to the underlying purposes of criminal system

6. See *id.* at 536–39; see also Nancy Wolff, *Are Mental Health Courts Target Efficient?*, INT'L J.L. & PSYCHIATRY, Mar.–Apr. 2018, at 67, 68 (noting that "offenders with mental illness are 'normal' in their criminal behavior insofar as the same criminogenic risk factors that motivate offenders without mental illness also motivate those with mental illness"); *Correctional Policy*, *supra* note 1, at 116–17 (noting that alternatives to the criminalization hypothesis assume that the causes of criminal behavior are largely shared by offenders with and without mental illness).

7. See Johnston, *supra* note 4, at 521.

8. *Id.*

9. See *id.* at 521, 523.

10. Cf. Jennifer L. Skeem et al., *Offenders with Mental Illness Have Criminogenic Needs, Too: Toward Recidivism Reduction*, 38 LAW & HUM. BEHAV. 212, 218–19, 221–22 (2014) [hereinafter *Toward Recidivism Reduction*] (finding an indirect relationship between mental illness and recidivism).

11. See Johnston, *supra* note 4, at 538–39.

12. See *id.* at 554–58.

coercion more generally.

The complex associations between serious mental illness and several of the key risk factors for criminal system involvement—most notably substance misuse—impact the design of effective programs intended to reduce reoffending. Given the practical difficulty of disentangling the treatment of mental disabilities from the provision of effective interventions to interrupt patterns of criminal behavior in offenders who have significant mental illness, some specialized attention to clinical mental health needs is warranted in correctional rehabilitation programs. These integrated programs are resource intensive, however, and should be reserved for offenders with serious mental illness who present the highest risk of reoffending. Others, who are lower risk, are strong candidates for diversion from the criminal system altogether, assuming that appropriate services in the community can be made available on a consistent basis.

I. CRIMINALIZATION THEORY

Central to the criminalization theory is the notion of transinstitutionalization, which holds that when states reduced the availability of psychiatric beds in state hospitals beginning in the 1960s and 1970s, displaced patients were forced into the community without adequate treatment and other essential services and therefore were drawn into jails and prisons, which became “de facto treatment facilities.”¹³ From this perspective, it is untreated, or undertreated, mental illness that accounts for much of the criminal system involvement of individuals with serious mental illness.¹⁴

13. Seth J. Prins, *Does Transinstitutionalization Explain the Overrepresentation of People with Serious Mental Illnesses in the Criminal Justice System?*, 47 CMTY. MENTAL HEALTH J. 716, 716–17 (2011).

14. *Id.* at 718. The criminalization theory has several constituent elements. First is the idea that “a constant segment of the mentally ill population will always require institutional care.” Justin L. Joffe, *Don’t Call Me Crazy: A Survey of America’s Mental Health System*, 91 CHL.-KENT L. REV. 1145, 1156 (2016) (footnote omitted). This notion can be traced to Lionel Penrose’s 1939 article, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, which argued that “[t]he population of every land may be presumed to contain a small section composed of people whose behaviour is so undesirable from the social point of view that they require segregation for a greater or lesser period of their lives” either through criminal confinement or by way of civil commitment. L. S. Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRIT. J. MED. PSYCH. 1, 1–15 (1939). The second element is an assumed “reciprocity and functional interdependence between the mental health and criminal justice systems whereby a decrease in capacity in one results in the expanded use of the other for individuals requiring institutional care.” Johnston, *supra* note 4, at 525. Taken together, these elements lead to the conclusion that a limited supply of inpatient beds in state hospitals and the application of libertarian rules that narrowed the scope of the state’s civil commitment power resulted in more undertreated individuals being held in jails and prisons that “in effect, serve the role of psychiatric inpatient services.” Prins, *supra* note 13, at 718.

Professor Johnston carefully goes through evidence that calls this account into question, demonstrating it to be reductionist in that it “mistakenly draw[s] a causal connection between two merely correlated trends: the decline in the availability of state psychiatric hospital beds and the rise in prevalence of [serious mental illness] in jails and prisons.”¹⁵ First, many offenders with serious mental illness would not have been treated as inpatients in state hospitals even before deinstitutionalization.¹⁶ Compared to offenders with severe mental illness currently in jails and prisons, patients in state hospitals prior to deinstitutionalization were more likely to be diagnosed with schizophrenia, were older, and were less likely to be African American or Latinx.¹⁷ In addition, the percentage of incarcerated offenders in the United States who have serious mental illness, as distinguished from the absolute number of such inmates, has not increased dramatically in recent decades.¹⁸ Instead, the increased number of inmates with serious mental illness seems to be a function of the overall increase in incarceration rates due to the war on drugs and other tough on crime policies implemented in the last quarter of the 20th century.¹⁹ Finally, the idea that most of the persons who formerly would have been treated as long-term inpatients in state hospitals now live in unstructured settings in the community where they are at risk of criminal system involvement, or are homeless, is inconsistent with evidence that many in this group are cared for in nursing homes and other specialized housing where they are “still institutionalized, not in their communities unsuccessfully attempting to access treatment for behaviors that might draw the attention of law enforcement officers.”²⁰

Another element of the criminalization theory centers on “differential policing,” or the idea “that—in light of a lack of community treatment options, bureaucratic hurdles to emergency hospitalization, and narrow civil commitment criteria—officers may opt to arrest individuals with mental illness for minor offenses as a means of securing treatment, an act that has been called ‘mercy booking.’”²¹ While there are some

15. Prins, *supra* note 13, at 720; see Johnston, *supra* note 4, at 526–30.

16. See Johnston, *supra* note 4, at 528; Prins, *supra* note 13, at 719.

17. See Johnston, *supra* note 4, at 528; Prins, *supra* note 13, at 719.

18. See Prins, *supra* note 13, at 719.

19. See Johnston, *supra* note 4, at 529. On the increase in rates of incarceration and the impact of the war on drugs on jail and prison populations in the United States, see generally Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom*, 62 S.C. L. REV. 261 (2010) [hereinafter *Drug Policy in Context*].

20. See Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 DREXEL L. REV. 1, 50–51 (2017) [hereinafter *Emergency Detention*] (quoting Prins, *supra* note 13, at 719).

21. Johnston, *supra* note 4, at 530. The high rate of homelessness among people with serious mental illness is also part of this narrative. “[T]he mere fact of living on the street can

observational studies that appear to confirm this idea,²² Professor Johnston identifies other research that, after controlling for “legally relevant and encounter-level factors,” finds persons with mental illness are no more likely to be arrested than others who encounter the police.²³ Indeed, there is even some data to suggest that those with mental illness are arrested less often in circumstances that would have led to the arrest of others.²⁴

The final element of the criminalization theory centers on the idea that criminal conduct often is the “manifestation” of serious mental illness.²⁵ A corollary to this intuition is the proposition that effective mental health treatment can reliably interrupt the cycle of criminal system involvement experienced by offenders with mental illness.²⁶ Here, as in her prior work, Professor Johnston effectively explains that most criminal conduct exhibited by those with serious mental illness is not “symptom-driven,” and therefore is not, properly speaking, a manifestation of their mental disabilities.²⁷ A small fraction of crimes committed by such individuals likely are the result of their delusions or hallucinations, and an equally small number are the result of anger, impulsivity, or confusion stemming from mental illness, but overall “for offenders, having a mental disorder was no more predictive of recidivism than not having a mental disorder.”²⁸

result in a series of arrests for nuisance behaviors that may cumulatively result in prison sentences.” Jennifer S. Bard, *How the 21st Century Cures Act Can Mitigate the Ever Growing Problem of Mass Incarceration*, 44 AM. J.L. & MED. 388, 391 (2018). In addition, “because people with mental illness may not respond quickly to instructions or behave as instructed, small incidents can escalate into major confrontations.” *Id.* at 388.

22. See Linda A. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 AM. PSYCH. 794, 798–99 (1984).

23. Johnston, *supra* note 4, at 531.

24. See *id.* at 531–32.

25. *Id.* at 532.

26. *Id.*

27. *Id.* at 532–35; see also E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 560–61 (2012). Professor Johnston stated that

[M]ental illnesses may directly contribute to the criminality of only about 10 percent of the mentally disordered offending population [F]or the remaining 90 percent of offenders with mental illnesses, the effect of mental illness on criminal activity is fully mediated by factors such as poverty or social learning that similarly affect the general population.

Id.

28. Johnston, *supra* note 4, at 533, 535.

II. NORMALIZATION THEORY AND THE RNR MODEL

In contrast to the criminalization theory, which regards offenders with serious mental illness as distinguished primarily by their disabilities, the normalization theory is based on the premise that “offenders with mental illness are ‘normal’ in their criminal behavior insofar as the same criminogenic risk factors that motivate offenders without mental illness also motivate those with mental illness.”²⁹ Adoption of this alternative framing leads, in turn, to a different approach to organizing rehabilitative services for offenders in general and for offenders with serious mental illness particularly.³⁰ Instead of concentrating treatment resources within the criminal legal system in specialized programs designed to address the clinical needs of mentally disabled offenders, the normalization theory urges the allocation of rehabilitative interventions based on the level of risk associated with the criminogenic needs of individuals in the system.³¹ As psychologist Donald A. Andrews and James Bonta, two leading proponents of this model, explain:

Offenders . . . have a right to the highest quality service for other needs, but that is not the focus of correctional rehabilitation. Striving to change noncriminogenic needs is unlikely to alter future recidivism significantly unless it indirectly impacts on a criminogenic need. We may help an offender feel better, which is important and valued, but this may not necessarily reduce recidivism.³²

The framework for operationalizing this approach is the widely accepted Risk-Need-Responsivity Model (RNR).³³ This model, which

29. *Id.* at 536.

30. *See id.* at 538–39.

31. *See id.* at 538–40.

32. D. A. ANDREWS & JAMES BONTA, *THE PSYCHOLOGY OF CRIMINAL CONDUCT* 244 (2d ed. 1998) [hereinafter *PSYCHOLOGY OF CRIMINAL CONDUCT*].

33. The RNR Model is considered the “dominant paradigm for working with offenders.” *CTR. FOR JUST. INNOVATION, PROBLEM-SOLVING COURTS: AN EVIDENCE REVIEW* 4 (2015). The model has, however, received important criticism from advocates of the Good Lives Model. The Good Lives critique is that

[The] RNR promotes prosocial behavior only insofar as it functions to reduce criminal behavior, whereas the GLM promotes prosocial behavior both that has the possibility to reduce criminal behavior *and* that provides the individual with an opportunity to live a satisfying life, the latter with which the RNR does not concern itself. The GLM, therefore, acknowledges intrinsic motivation for behavior and goes beyond viewing the person as the passive recipient of behavioral contingencies, while also acknowledging the influence of these contingencies on criminal behavior.

Tony Ward et al., *The Good Lives Model and the Risk Need Responsivity Model: A Critical Response to Andrews, Bonta, and Wormith*, 39 *CRIM. JUST. & BEHAV.* 94, 101 (2012).

was developed in the early 1990s, is comprised of the principles of risk, need, and responsivity.³⁴ The *risk* principle asserts that the intensity of a criminal system intervention intended to diminish recidivism should be matched to an offender's level of risk.³⁵ To accomplish this risk matching, proponents of the RNR model encourage the use of empirically validated risk assessment tools that measure both static risk factors, such as age and criminal history, and dynamic risk factors.³⁶ The *need* principle states that treatment to reduce recidivism should target the particular set of criminogenic needs presented by a given offender.³⁷ The focus here is on "addressing an offender's set of dynamic criminogenic needs—those psycho-social-biological factors proven to influence and maintain criminal behavior—as opposed to focusing on other needs that are more distally related to offending."³⁸ The *responsivity* principle requires that interventions be designed to take into account the characteristics of individual offenders that are most likely to undermine their engagement with (and success in) rehabilitative programs.³⁹ Treatments based on cognitive social learning methods are thought to be the most effective at reducing criminal conduct,⁴⁰ and "intervention strategies tailored to match the offender's individual learning styles, motivations, and abilities (e.g., physical disabilities, mental health, level

34. See D. A. Andrews et al., *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19–20 (1990).

35. *Id.* at 20. Indeed, there is some evidence that requiring high intensity interventions may increase reoffending in low risk offenders. See Johnston, *supra* note 4, at 540–41.

36. See JAMES BONTA & D. A. ANDREWS, RISK-NEED-RESPONSIVITY MODEL FOR OFFENDER ASSESSMENT AND REHABILITATION 5, 9 (2007) [hereinafter RISK-NEED-RESPONSIVITY MODEL]. There is considerable debate concerning the increasing reliance by corrections officials on risk assessment tools. Some writers have raised concerns about the inadequate cross-validation of some risk assessment tools, while others note low levels of inter-rater reliability. See, e.g., Donna Cropp Bechman, *Sex Offender Civil Commitments: Scientists or Psychics?*, CRIM. JUST., Summer 2001, at 24, 28–29; Marcus T. Boccaccini et al., *Do PCL-R Scores from State or Defense Experts Best Predict Future Misconduct Among Civilly Committed Sex Offenders?*, 36 LAW & HUM. BEHAV. 159, 167–68 (2012).

37. Andrews et al., *supra* note 34, at 20.

38. Johnston, *supra* note 4, at 541; see Richard C. Boldt, *Problem-Solving Courts*, in ACAD. FOR JUST., REFORMING CRIMINAL JUSTICE 291–92 (Erik Luna ed., 2017) [hereinafter *Problem-Solving Courts*] ("Thus, instead of focusing solely on drug use treatment for persons with drug problems or medication management for offenders with mental illness, the need principle calls for the delivery of an integrated suite of services designed to meet all (or at least most) of the deficits that collectively contribute to their criminal involvement."); see also Mary Ann Campbell et al., *Multidimensional Evaluation of A Mental Health Court: Adherence to the Risk-Need-Responsivity Model*, 39 LAW & HUM. BEHAV. 489, 490–91 (2015) (noting that in the mental health court context, the RNR model supports a case management plan that emphasizes the importance of treating criminogenic needs directly tied to criminal behavior in conjunction with mental health specific interventions).

39. Andrews et al., *supra* note 34, at 20.

40. See Francis T. Cullen, *Rehabilitation: Beyond Nothing Works*, CRIME & JUST., Aug. 2013, at 299, 341–43.

of intelligence) are encouraged.”⁴¹

Professor Johnston reports that a “groundswell is building to apply the RNR model to offenders with serious mental illness.”⁴² “[F]ederal agencies, policy advocates, and social scientists” are coming to agreement that the model should govern the allocation of rehabilitative resources within the criminal legal system.⁴³ However, notwithstanding this developing consensus, little of the treatment currently offered to offenders with serious mental illness in specialty programs in fact “coheres with the RNR model.”⁴⁴ Instead, so called first-generation treatment programs like mental health courts are still based on the criminalization model.⁴⁵ Apparently, an “uncritical stance” seems to have led many decision makers within the criminal legal system to continue supporting plainly inefficient programs.⁴⁶ This mismatch between theory and practice may be the result of officials’ stubborn refusal to engage the best evidence available on criminal system rehabilitation, or it could be a product of the sort of policy inertia that often attends paradigm-level shifts in governing models.⁴⁷ But the various justifications, identified by Professor Johnston, for the continued support of first-generation specialty programs likely is doing much of this work. These justifications, therefore, warrant more focused attention.

III. JUSTIFICATIONS FOR THE PERSISTENCE OF SPECIALIZED MENTAL HEALTH TREATMENT INTERVENTIONS

The first justification regards serious mental illness as an appropriate target of treatment in criminal system-located rehabilitation programs because these disabilities stand as an obstacle impeding the effectiveness of measures intended to redress criminogenic needs.⁴⁸ On this account, specialized programs to treat offenders’ mental illness are warranted, even if mental illness is not independently predictive of reoffending, when the recipients of those services suffer from particularly severe disorders that require clinical intervention before other measures to address criminogenic needs can be implemented.⁴⁹ This justification is not limited to circumstances in which offenders are so decompensated that they are unable to engage with rehabilitative services; rather, it

41. *Problem-Solving Courts*, *supra* note 38, at 292; *see also* Johnston, *supra* note 4, at 541–42 (distinguishing general and specific responsibility).

42. Johnston, *supra* note 4, at 545.

43. *Id.*

44. *Id.* at 548.

45. *Id.*

46. *Id.* at 549–50.

47. *See id.*

48. *See id.* at 554.

49. *See id.* at 554–55.

subsumes the greater universe of offenders whose “mental illness functions as a moderator of intervention effectiveness, such that successfully addressing the mental illness increases the effectiveness of interventions targeting criminogenic needs.”⁵⁰

The second justification for specialized mental health treatment is related to the first but does not impose a sequential logic on the relationship between mental illness and the effective treatment of criminogenic needs, and does not require that treatment for mental illness precede other rehabilitative interventions.⁵¹ Instead, this justification contemplates that mental illness and criminogenic needs “may be reinforcing or even synergistic.”⁵² Thus, even if an offender’s mental illness is not the direct cause of her criminal system involvement, this justification suggests it might be so bound up with other dynamic risk factors that the effective targeting of the one requires careful and simultaneous attention to the other.⁵³

The third justification noted by Professor Johnston is derived from the very idea that rehabilitative treatment must be responsive to the particular characteristics of offenders, which is a central feature of the RNR model.⁵⁴ Some responsivity factors, such as cultural or language barriers, are external to the individual recipient of services but still require attention if social and behavioral learning resources are to be effective in addressing criminogenic needs and risks.⁵⁵ Others are internal, and may include barriers to rehabilitation that result from age, physical, or mental disability.⁵⁶ These internal responsivity factors may produce anxiety, confusion, depression, or anger, and they—like external factors—must be addressed if an offender’s recidivism risk is to be reduced.⁵⁷ On this logic, specialized mental health treatment may be appropriate given that “modifications to general correctional interventions may be necessary to address the particular treatment needs, cognitive and emotional impairments, and delivery requirements of offenders with serious mental illness.”⁵⁸

Taken together, these justifications unsettle the suggestion implied in

50. *Id.* at 555.

51. *See id.*

52. *Id.*

53. *See* Jennifer L. Skeem et al., *Applicability of the Risk-Need-Responsivity Model to Persons with Mental Illness Involved in the Criminal Justice System*, 66 *PSYCHIATRIC SERVS.* 916, 920 (2015) [hereinafter *Applicability of the Risk-Need-Responsivity Model*].

54. *See* Johnston, *supra* note 4, at 557–58.

55. *See id.* at 542.

56. *See id.*

57. *See id.*; *see also* Jan Looman et al., *Responsivity Issues in the Treatment of Sexual Offenders*, 6 *TRAUMA, VIOLENCE & ABUSE* 330, 345 (2005) (discussing various internal responsivity factors).

58. Johnston, *supra* note 4, at 558.

the unamended normalization thesis that offenders with serious mental illness are like other offenders in their relationship to criminogenic need and risk.⁵⁹ For the reasons that Professor Johnston suggests, these justifications do not provide a sufficient basis for specialized first-generation programs like mental health courts that prioritize the treatment of mental illness to the exclusion of other services designed to mitigate criminogenic risk factors,⁶⁰ but they may provide good reasons for “next generation” specialty programs that thoughtfully integrate mental health treatment into a coordinated suite of interventions that are guided by the principles of the RNR model.⁶¹

This is the case particularly with respect to mentally ill offenders who misuse alcohol or other drugs. One of the “Central Eight” criminogenic risk factors is substance misuse, which frequently is a co-occurring disorder with serious mental illness.⁶² Well-established RNR principles call for the application of treatment resources to manage or ameliorate substance use disorders (SUD) as part of a rehabilitative program addressing offenders’ criminogenic needs.⁶³ If, however, the relationship between serious mental illness and SUD is such that the success of substance use treatment is contingent on the provision of other treatment for co-occurring mental illness, then it might be sensible to invest in the resources needed to effectively treat both of these linked clinical needs,

59. *See id.* at 536. A final justification identified by Professor Johnston for specialized programs for offenders with serious mental illness follows from the observation that even though most criminal conduct committed by these offenders is not a direct manifestation of their illness, in a minority of cases it is. *Id.* at 558. One difficulty with implementing programming on this basis is that “symptom-based crimes do not cluster by person,” which makes it difficult to target mental health treatment precisely to those whose disabilities most likely directly cause reoffending. *Id.* Nevertheless, some number of criminal events apparently are the direct result of symptoms associated with serious mental illness and this would appear to support a vestigial form of the criminalization thesis. As a matter of policy development and implementation, though, no single uniform approach is likely to be effective or practical in addressing this subset of symptom-driven crime, given that there is such diversity among offenders with serious mental illness. As Professor Johnston points out:

Serious mental illness is not a single conglomerate with a uniform set of features. Indeed, no single mental illness has stable or uniform aspects. Therefore, different mental illnesses may fall within the ambit of different justifications and may satisfy multiple justifications simultaneously or across time. To justify a specialized criminal justice program, it may be unnecessary to scientifically verify a particular justification for a particular diagnosis or set of individuals.

Johnston, *supra* note 4, at 559 (footnote omitted).

60. *See id.* at 551.

61. *Id.* at 559–60.

62. *Id.* at 536; *see also* Arthur J. Lurigio et al., *Standardized Assessment of Substance-Related, Other Psychiatric, and Comorbid Disorders Among Probationers*, 47 INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY 630, 644 (2003).

63. Johnston, *supra* note 4, at 529, 544–45.

either in sequence or simultaneously.⁶⁴

Professor Johnston adopts a somewhat skeptical position on specialized programs that prioritize mental health treatment to facilitate the delivery of other rehabilitative services, noting the limited research data on mental illness as a “specific responsivity” factor.⁶⁵ Discussing important work by clinical psychologist Sarah McCormick and her colleagues, Professor Johnston concludes that

it is currently unclear how—and whether—mental illness may function in this way, either by allowing for the identification and treatment of more criminogenic needs or by increasing that treatment’s effectiveness at reducing recidivism. As of yet, there is no evidence to support the latter hypothesis, and only nascent evidence to support the former.⁶⁶

At least with respect to programs designed for offenders who have both mental illness and substance use disorders, however, Professor Johnston may be imposing too demanding a standard. As noted, the frequent co-occurrence of substance use disorders in individuals with serious mental illness is well established.⁶⁷ Although the etiology of this comorbidity is not well understood and is likely the result of different factors for different subgroups in this population,⁶⁸ the prevalence and nature of this comorbidity support instituting programs targeting mental illness as one significant component in an integrated plan for addressing other criminogenic needs and risks, even if the evidence to support the “specific responsivity” hypothesis is thin.⁶⁹

IV. THE COMORBIDITY OF SUBSTANCE USE DISORDERS AND MENTAL ILLNESS

The unamended normalization thesis leads to the conclusion that “[a] correctional system in accord with RNR principles would prioritize

64. See *Applicability of the Risk-Need-Responsivity Model*, *supra* note 53, at 920 (“When clinical factors potentiate general risk factors, they become part of the criminogenic story that should be assessed and targeted with services that are ‘wise’ to their interaction.”).

65. Johnston, *supra* note 4, at 543–44.

66. *Id.* at 555 (footnote omitted) (discussing Sarah McCormick et al., *The Role of Mental Health and Specific Responsivity in Juvenile Justice Rehabilitation*, 41 *LAW & HUM. BEHAV.* 55, 63 (2017)).

67. See *supra* note 62; see also JAMES & GLAZE, *supra* note 1, at 5 tbl.5 (roughly 75% of offenders in state prisons or local jails, and over 60% of offenders in federal prison, with mental disorder struggle with substance dependence or abuse).

68. See Kim T. Mueser et al., *Dual Diagnosis: A Review of Etiological Theories*, 23 *ADDICTIVE BEHAV.* 717, 717–18, 728 (1998).

69. Johnston, *supra* note 4, at 543–44.

treating the criminogenic needs of those offenders who are at the highest risk of reoffending, *regardless of their noncriminogenic needs.*⁷⁰ The subset of offenders with comorbid SUD and mental illness whose amenability to rehabilitative interventions is dependent on the effective management of their mental illness are not “normal” in this sense.⁷¹ They may fall into the group with the highest risk of reoffending precisely because of the complex combination of behavioral health problems they present and may require specialized mental health treatment even if their mental illness is not, taken in isolation, a criminogenic risk.⁷²

The relationships between the various categories of serious mental illness and co-occurring drug use disorders are difficult to describe, and the relative effectiveness of different clinical interventions are even more difficult to measure.⁷³ As a general matter, there are four comorbidity models that seek to explain the extremely high levels of co-occurrence between serious mental illness and substance use disorders.⁷⁴ First, the common factor model “posit[s] that high rates of comorbidity are the result of shared vulnerabilities to both disorders.”⁷⁵ A second model views substance use disorders as secondary to serious mental illness.⁷⁶ Individuals with serious mental illness may be vulnerable to developing a secondary SUD because of psychosocial risk factors, a need to self-medicate against the effects of mental illness, or because serious mental illness creates a “supersensitivity” to various substances of abuse.⁷⁷

70. *Id.* at 551 (emphasis added). Professor Johnston’s reliance on the RNR model and the normalization thesis supports the conclusion that treatment resources should be allocated to offenders at the highest risk of recidivism, whether or not they have psychiatric illness. While Professor Johnson does not insist that treatment plans disregard mental disorder, the weak empirical evidence with respect to mental illness as a specific responsivity factor presumably does impact her judgment with respect to the appropriate allocation of limited treatment resources.

71. *Id.* at 536.

72. *See id.* at 556–57.

73. On the complex and diverse mechanisms of association between serious mental illness and substance use disorders, see generally Mueser et al., *supra* note 68. On the comorbidity of depression and SUD, see Joel D. Swendsen & Kathleen R. Merikangas, *The Comorbidity of Depression and Substance Use Disorders*, 20 *CLINICAL PSYCH. REV.* 173 (2000). On the associations between, and implications for the treatment of, post-traumatic stress disorder and substance misuse, see Sherry H. Steward et al., *Functional Associations Among Trauma, PTSD, and Substance-Related Disorders*, 23 *ADDICTIVE BEHAVS.* 717 (1998).

74. *See* Mueser et al., *supra* note 68, at 718. Researchers in this field believe that different mechanisms of comorbidity may explain the dual diagnosis of different groups of patients, and more than one model may apply to any given individual. *See id.* at 718–19.

75. *Id.* at 719. These shared vulnerabilities could be genetic or they could derive from personality disorders or socioeconomic conditions. *Id.* at 719–21.

76. Mueser et al., *supra* note 68, at 722.

77. *Id.* at 722–24. While there is insufficient evidence to support the self-medication thesis, the supersensitivity theory may well account for a fair amount of the overlap between these disorders. “The research reviewed provides support for the hypothesis that patients with [serious

Alternatively, a third model suggests that mental illness may be secondary to sustained substance misuse. This possibility is based on a well-established model “in which psychobiological vulnerability to schizophrenia (or bipolar disorder) may be triggered by a stressor (in this case, a biological stressor in the form of drug abuse), resulting in the psychiatric syndrome.”⁷⁸ A final bidirectional model suggests that “ongoing, interactional effects” between serious mental illness and substance use disorders help to explain the high rates of comorbidity.⁷⁹ Under this model, either disorder could play a role in triggering vulnerabilities that lead to the development of the other, and each then works to sustain their ongoing co-occurrence.⁸⁰

Whatever the precise mechanism that accounts for the high rate of comorbidity between any given mental illness and substance misuse, and whatever its etiology, the complexity and heterogeneity of the problem make it unlikely that a clear empirically demonstrated causal account can be developed through ordinary research methods.⁸¹ It is one thing to show the limited causal impact of serious mental illness when other criminogenic factors are controlled for; it is quite another to consider its impact in a dynamic system in which substance misuse and mental illness so frequently are intertwined. Professor Johnston acknowledges this practical difficulty, noting that

establishing the scientific validity of some of these justifications—particularly those involving mental illness as a responsivity factor—in isolation would be very difficult given pragmatic data availability and clinical control feasibility. This is especially the case considering that serious mental illness and criminogenic risk factors, if they are related, may interact as part of an emergent system that does not lend itself to reductive efforts to test individual variables independently.⁸²

Recognizing these serious limitations in the research, it would seem a practical impossibility to disentangle the treatment of criminogenic

mental illness] are prone to experience negative consequences from lower amounts of substance use than people in the general population, which could explain at least some of the excess comorbidity.” *Id.* at 724.

78. *Id.* at 727. “Once triggered, a drug-induced schizophreniform psychosis may be indistinguishable from a similar disorder either brought on by a socioenvironmental stressor or due to a sufficient amount of biological vulnerability.” *Id.*

79. *Id.*

80. *See id.*

81. On the difficulties of studying causation in the context of a comorbid mental illness and SUD, see Howard D. Chilcoat & Naomi Breslau, *Investigations of Causal Pathways Between PTSD and Drug Disorders*, 23 ADDICTIVE BEHAVS. 827 (1998).

82. Johnston, *supra* note 4, at 559 (footnote omitted).

substance misuse from the treatment of co-occurring serious mental illness in the many offenders who suffer from both. This practical reality has led Professor Jennifer Skeem and her colleagues to suggest that, because “the noncriminogenic risk factor of mental illness may both attract and exaggerate the effect of the criminogenic risk factor of substance abuse[,]” the treatment of serious mental illness may be an appropriate component of an RNR-informed system.⁸³

An approach that places the treatment of substance misuse at the center of the constellation of appropriate correctional rehabilitative services but rules treatment for mental illness to be of marginal importance is suspect for yet another reason. Much of the logic that supports moving mental health treatment out of specialized criminal system rehabilitation programs also supports moving specialized substance use treatment into the community as well. The long history of drug regulation in the United States, from the early 20th century through the war on drugs at the end of the last century to the present moment, teaches that substance misuse, like mental illness, is primarily a public health problem better addressed by health officials and not in the first instance by the criminal legal system.⁸⁴ In addition, the risk component of the RNR model, as applied to offenders with behavioral health problems, directs that only high risk offenders should receive intensive correctional services.⁸⁵ On this understanding, broadly including substance misuse as a criminogenic risk of interest while categorizing mental illness as orthogonal to the concerns of the RNR model is problematic. Such a differentiated understanding of mental illness versus SUD may reflect their relative causal contributions to the risk of reoffending when evaluated in the abstract and through regression analysis. But in the real world, given the complex and intensive comorbidity of these behavioral health disorders, an approach that integrates mental health treatment into a full range of rehabilitative services and then reserves this intensive treatment for only the highest

83. *Id.* at 557 (footnote omitted). Professor Skeem and colleagues point out that a “reason to avoid focusing services too exclusively on general risk factors is that these variables may sometimes interact with mental illness to exponentially increase risk.” Skeem et al., *supra* note 53, at 920.

The risk component of the RNR model encourages decisions about rehabilitative programming to be made on the basis of individualized risk assessments. It may be possible to identify the subset of offenders who, because of their co-occurring serious mental illness and SUD, are at high risk of recidivism and to direct resources to those offenders in particular, but the demands for treatment resources both within the corrections system and in the community necessarily compete with the allocation of those services within the criminal system. In addition, the limitations of the risk assessment process itself, *see supra* note 36, make this a difficult basis for making resource triage decisions.

84. *See Drug Policy in Context*, *supra* note 19, at 269–309.

85. Johnston, *supra* note 4, at 560, 563.

risk offenders is a much more sensible use of limited resources.⁸⁶

V. ASSESSING REHABILITATIVE GOALS OTHER THAN THE REDUCTION OF RECIDIVISM

Some advocates for mental health courts and other specialized criminal system-based programs that prioritize the treatment of serious mental illness cite pragmatic grounds not tied directly to the reduction of criminal reoffending. This alternative argument draws on research suggesting that treatment programs reinforced by criminal system coercion can be effective in reducing other costs generated by untreated mental illness that are borne by emergency departments, other components of the public mental health system, and other elements of the social safety net.⁸⁷ Similar arguments have been made in support of other specialty programs targeting offenders with behavioral health problems, including drug courts and other problem-solving courts.⁸⁸

A central question raised by this alternative ground is whether it is fair or wise to focus limited treatment resources on those who commit criminal offenses as opposed to others with serious mental illness not enmeshed in the criminal legal system. A ready response is that treatment programs reinforced by the threat of criminal law sanctions produce improved outcomes by linking offenders to treatment and increasing the likelihood that they will be retained long enough to receive a therapeutic dose.⁸⁹ In the absence of clear evidence that this coerced treatment

86. In comments on a draft of this response essay, Professor Johnston noted:

I am not certain we should assume a substantial proportion of those with comorbid SMI and SUD are at the highest risk of recidivism. Indeed, the RNR Simulation Tool, developed to assist justice agencies in better allocating treatment resources to reduce recidivism, recommends that only a small percentage (3% to 5%) of high-risk offenders in each correctional modality (prison, jail, community corrections) should receive treatment for substance abuse or mental disorders. (A much higher percentage of moderate-risk offenders is recommended for substance abuse or mental health treatment: 40% of moderate-risk prisoners, 31% of jail inmates, and 36% of those on community supervision.)[.]

Letter from E. Lea Johnston, Rsch. Found. Professor, Univ. of Fla. Levin College of Law, to author (July 10, 2020) (on file with author).

Given limited correctional resources and limited mental health treatment resources, specialized services for the treatment of substance misuse and mental illness should be restricted to only those offenders who are at the highest risk of reoffending.

87. See Johnston, *supra* note 4, at 565–66.

88. See, e.g., Judith S. Kaye, *Delivering Justice Today: A Problem-Solving Approach*, 22 YALE L. & POL'Y REV. 125, 128–29 (2004).

89. See Douglas B. Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision*, SCI. & PRAC. PERSPS., Aug. 2003, at 4, 5; see also Douglas M. Anglin & Yih-ing

advances the goal of reducing criminal recidivism, however, the use of criminal punishment as a therapeutic lever may well be inappropriate.⁹⁰ As a rule, having a need for substance use or mental health treatment should never be a sufficient reason for an individual's entry into the criminal legal system, and the criminal system should never be the only or primary means of obtaining needed treatment.⁹¹

CONCLUSION

It is clear from Professor Johnston's compelling analysis that the criminalization theory, on its own, is not a sufficient basis for the specialized treatment too often directed uncritically at offenders with serious mental illness. On the other hand, the prevalence and intensity of the comorbidity between substance use disorders and serious mental illness support next-generation programs that, consistent with the RNR model, include specialized mental health treatment services alongside treatment for SUD for high risk offenders. Professor Johnston notes that the commitment of significant treatment resources to first-generation specialty programs for offenders with mental illness may undermine the ability of officials responsible for the operation of jails and prisons to provide a minimally adequate level of mental health treatment, as required by statutory and constitutional standards governing access to health care.⁹² She clearly is correct in this assessment, but this logic

Hser, *Legal Coercion and Drug Abuse Treatment: Research Findings and Social Policy Implications*, in HANDBOOK OF DRUG CONTROL IN THE UNITED STATES 151–52 (James A. Inciardi ed., 1990).

90. In fact, “[a]ccording to one major study from the Washington State Institute for Public Policy . . . adult drug courts reported a reduction in recidivism of 8.7 percent . . . on par with reduction recorded by programs offering community-based drug treatment (8.3 percent).” DRUG POL’Y ALL., DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 11 (2011). Similar data call into question the relative effectiveness of mental health courts in reducing recidivism. See Evan M. Lowder et al., *Effectiveness of Mental Health Courts in Reducing Recidivism: A Meta-Analysis*, 69 PSYCHIATRIC SERVS. 15, 15 (2018) (“Overall, a small effect of MHC participation on recidivism was noted, compared with traditional criminal processing. Findings suggest the need for research to identify additional sources of variability in the effectiveness of MHCs.”). But see Christine M. Sarteschi et al., *Assessing the Effectiveness of Mental Health Courts: A Quantitative Review*, 39 J. CRIM. JUST. 12, 18 (2011) (reporting evidence of some effectiveness of mental health courts in reducing recidivism). In the event that criminal system enforced treatment is deployed not primarily to reduce reoffending but instead to reduce other societal costs, one could rely on legal philosopher H.L.A. Hart’s notion that, if limited by an assessment of proportional desert, coercive interventions designed to serve other consequentialist goals are permissible as a moral matter. See H.L.A. Hart, *Prolegomenon to the Principles of Punishment*, in H.L.A. HART, PUNISHMENT AND RESPONSIBILITY 1–27 (1968). Hart’s focus, however, was on the consequentialist goal of deterrence, not other utilitarian aims removed from the prevention of future offending. *Id.* at 9.

91. Cf. DRUG POL’Y ALL., *supra* note 90, at 4 (setting out these principles as a component of a “health-centered approach” to drug use).

92. See Johnston, *supra* note 4, at 552–53.

applies to specialty programs for offenders with SUD as well, including drug courts and other specialized programs that seek to deploy the coercive authority of the criminal system to encourage offenders to engage treatment. Therefore, for lower risk offenders with mental illness and for offenders with comorbid SUD, the wise allocation of scarce treatment resources requires that these behavioral health risks be dealt with primarily outside of the criminal legal system and independently of criminal system coercion.⁹³

93. One promising approach to relocating behavioral health interventions outside of the criminal legal system is the Sequential Intercept Model, which “envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system.” See Mark R. Munetz & Patricia A. Griffin, *Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness*, 57 PSYCHIATRIC SERVS. 544, 544 (2006).