to 33 percent of untreated inmates.

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Interfaces Between Criminal Behavior, Alcohol and Other Drug Abuse, and Psychiatric Disorders

—Bert Pepper, M.D., psychiatrist and executive director, The Information Exchange, Inc., New City, New York

The public has become increasingly concerned about the many connections between alcohol/other drug abuse and criminal behavior. Daily, the newspapers carry stories of psychotic addicts committing violent crimes; of cases of vehicular manslaughter due to driving under the influence; of the drug cartels murdering public officials who interfere with drug trafficking. For the public today, criminal behavior associated with alcohol and other drug abuse is a major concern.

State and Federal prisons and our local jails. Clinical experience and early research results suggest that this population requires integrated combined treatments for more than one disorder if recidivism is to be reduced, treatment is to be successful, and the public is to be protected.

It is time to encourage debate about the multiple factors which interconnect criminal behavior with alcohol/other drug abuse, sometimes

We are increasingly aware that the dually disordered constitute the bulk of the "new prisoner" population of our State and Federal prisons and our local jails. Clinical experience and early research results suggest that this population requires integrated combined treatments for more than one disorder ...

At the same time, professionals in criminal justice, substance abuse, and mental health have become increasingly aware of the interaction between their fields. The complex interactions between alcohol/other drug abuse, mental illnesses, and criminal acts have become serious interprofessional concerns.

Terms for this population

Different States have their preferred term for this overlap population: MICA (Mentally Ill Chemical Abuser); CAMI (Chemically Abusing Mentally Ill); dual diagnosis; dual disorders. The Federal agencies prefer the term co-morbidity; some researchers speak of the co-disordered.

Whatever the term, we are increasingly aware that the dually disordered constitute the bulk of the "new prisoner" population of our

via the subtle mechanisms of psychiatric symptoms and disorders. A place to begin is with ten facts drawn from clinical experience; these facts are in the process of being evaluated and confirmed by research.

Ten Facts About Crime, Alcohol/Other Drug Use, and Mental Illness

1. Psychiatric patients who do not abuse alcohol or street drugs are no more likely to commit crimes than the public at large.

2. Alcohol is responsible for more criminal behavior than any other drug, and perhaps as much as for all other drugs combined. The sedating effects can lead to errors of judgment about distance and speed, or to falling asleep at the wheel. The disinhibitory effects can lead to a variety of impulsive and illegal acts, such as rape and child sexual abuse. The reduction of rage control, perhaps by reducing 5-hydroxy tryptophan, can lead to violence.

3. Underaged drinking and any use of such drugs as marijuana, cocaine, heroin, LSD, and PCP, is itself illegal. In addition, such use often leads to a variety of other criminal activities. Prostitution, smuggling, and drug sales are but a few examples.

4. Psychiatric disorders and their symptoms frequently lead to alcohol/other drug abuse, which may in turn lead to crime. This is in part explained by the self-medication hypothesis. It is supported by data from the National Institute of Mental Health (NIMH), which indicate that, in a dually disordered individual, the odds are 2.6 to 1 that psychiatric symptoms will occur before the person begins abuse of alcohol or other drugs.

5. Psychiatric patients who abuse alcohol and other drugs have an increased incidence of severe, sometimes violent psychotic episodes and out-of-control behavior.

6. Abuse of cocaine, alcohol, marijuana, PCP, LSD, and other drugs is highly correlated with violent psychosis.

7. Use and abuse of alcohol/other drugs often cause psychiatric symptoms, leading to an error in diagnosis. In susceptible individuals, alcohol/other drug abuse can cause:

- Symptoms of psychotic illness, such as schizophrenia
- Panic and other symptoms of anxiety disorders
- Depressive symptoms of varying degrees of intensity

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Such drug-induced symptoms usually clear only after complete discontinuation of the alcohol and other drug abuse. Even after the individual is abstinent, symptoms may persist for weeks, months, or even longer.

*8. Psychiatric disorders per se tend to lead to **inhibition** of action, whereas alcohol/other drug abuse may sometimes lead to inhibition but more often leads to **disinhibition**.*

9. Professional criminals who are not mentally ill often rely on the disinhibitory effect of their alcohol/other drug use to overcome fear and anxiety so that they can carry out criminal acts.

10. Certain crimes, such as vehicular homicide and spouse/child abuse, are highly correlated with alcohol/other drug use.

Consideration of these ten factors leads to a possible classification of criminal acts related to substance abuse and/or mental disorders (see box). Given the complexity of the situation, is it any wonder that judges, mental health and substance abuse professionals, and the public may be confused about what is *cause* and what is *effect?* The classification guidelines in the box at the right are offered to provide some help in sorting out and separating these complex sets of linked events.

Improved decision making in the criminal justice system

Greater knowledge of the nature of alcohol abuse, substance abuse, intoxication, disinhibition, and the time frames of action of different drugs and alcohol may lead to better decision making in the criminal justice system. Increased knowledge of the nature of psychiatric symptoms and disorders is equally important. And, of course, decision makers need information about the

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Classification Guidelines
Criminality, Alcohol and Other Drug Use, and Mental Illness

I. Purely criminal

When professional criminals use alcohol and other drugs to assist them in committing criminal acts (e.g., to reduce fear), such acts are **not** the product of substance abuse or mental disorder.

II. Purely criminal

A substance abuser may commit sane criminal acts in order to acquire funds for the purchase of drugs, or as a participant in a pattern of criminal behavior associated with the drug trade. Such acts are **not** the product of substance abuse.

III. Purely criminal

A sane criminal may, after being apprehended for a criminal act which the person fully intended to commit, fall back upon a substance abuse or mental illness defense in order to be treated more leniently by the judicial system. Such an act is **not** due to mental illness or to alcohol/other drug abuse.

IV. Criminal acts caused by alcohol/other drug abuse

A non-mentally ill individual who is intoxicated may commit a criminal act because of drug-induced disinhibition or anger/rage. The courts have varied in their determination of responsibility in such cases. If the individual had little prior experience with his or her behavioral response to intoxication, the court may be lenient, blaming the drug more than the user. However, in cases where the individual has been in trouble many times before because of intoxication but has refused treatment, there is a tendency to hold the person responsible, at least to some degree.

V. Criminal acts caused by substance abuse

A non-mentally ill substance abuser may experience an organic, substance-induced psychotic episode, which can lead to a violent criminal act. In such a case, the substance abuse may be seen as primary. However, the role of substance abuse in such cases is often missed, and the mental illness is incorrectly determined to be fully causative.

VI. Criminal acts caused primarily by mental illness and secondarily by alcohol/other drug abuse

A mentally ill person may attempt to self-medicate psychiatric symptoms with alcohol/other drugs; this may in turn lead to a reduction in behavioral inhibition and/or an increase in persecutory, paranoid, or psychotic thinking. The final consequence may be a violent or criminal act. Here, the mental illness is primary and the substance abuse is secondary.

VII. Criminal act caused by mental illness

A mentally ill person, usually in the grip of psychotic paranoid delusions or hallucinations, may commit an act of violence. This kind of case is rare and is covered by the traditional insanity defense (that is, by McNaghten).

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interactions between substance abuse and mental illness in order to make informed judgments.

We must seek to:

1. Provide judges, criminal justice and corrections personnel, and clinical practitioners with information about the nature of mental illness and its symptoms. Equally, they need knowledge about drug effects, so that they can evaluate evidence being presented based on their understanding of timing/sequencing: Which event comes first and leads to the next. Finally, they all should be well informed about the new knowledge of dual disorders that has emerged in the past few years.

Decision makers need information about the interactions between substance abuse and mental illness in order to make informed judgments.

2. Train substance abuse and mental health professionals who work in the criminal justice system to take a good history of both psychiatric disorders and substance abuse. When an adequate dual disorders/criminal behavior diagnostic decision-tree is integrated into the presentence report, this decision-tree provides useful information for the judge.

3. Provide updated training for treatment personnel. Since modern clinical approaches to dual disorder diagnosis and treatment are only a few years old, even experienced mental health and substance abuse professionals need to update their training.

4. Provide treatment. Both psychiatric disorders and substance abuse disorders should be treated in jail and prison as well as in supervised community corrections programs. A knowledge of which disorder came first, but also, of which must be the immediate focus of treatment, can guide treatment planning and enhance treatment effectiveness.

Directions for the 1990s

We have built enough jail and prison cells to house well over a million prisoners without really denting the problem of street crime. It is time to ask ourselves why the "lock 'em up" solution of the 1980s has failed. As we look at the nature of our new prisoner population, the answer appears to be that the majority of the new prisoners are substance abusers, mentally ill, or dually disordered.

Punishment has not worked. Coerced treatment has been shown to be as effective as voluntary treatment. As the tide now turns, more jurisdictions (such as Texas) are deciding to give treatment a chance.

An urgent word of caution is in order. We must avoid being naive or simplistic. Complex problems require complex solutions. Most of the mental health and substance abuse treatment personnel in the criminal justice and corrections systems will require upgraded training and powerful administrative support before they can carry out their mission for the 1990s. ■

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Treatment Planning Charts

CSAT has developed a Criminal Justice Treatment Planning Chart which shows the major "opportunity points" for intervening with substance-abusing offenders. This flow chart graphically suggests intersystems coordination at certain points: the points at which decisions and linkages may most productively be made between the criminal justice and substance abuse treatment systems. A similar chart for linkage points with offenders in the juvenile justice system has also been developed.

These charts may be ordered from the National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852 (telephone 1-800-729-6686 or 301/468-2600 locally). Order No. PH 295 for the Criminal Justice Treatment Planning Chart and Order No. PHD 598 for the Juvenile Justice Treatment Planning Chart.