DEINSTITUTIONALIZATION AND THE INCREASED INVOLVEMENT OF THE MENTALLY ILL WITH THE CRIMINAL JUSTICE SYSTEM

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A RESEARCH PAPER

Presented for the

Master of Science

Degree

Austin Peay State University

Sherill Jean Gilliam

December 1993

ACKNOWLEDGEMENTS

The author wishes to express sincere appreciation to Dr. Garland E. Blair, Professor of Psychology, Austin Peay State University, for his guidance and time given during the composition of this paper. Appreciation is also extended to Dr. Stuart B. Bonnington and Dr. Samuel S. Fung for their suggestions and assistance.

ABSTRACT

This review was concerned with literature addressing the involvement of the mentally ill with the criminal justice system since deinstitutionalization. A brief history of the deinstitutionalization and community mental health movements was presented. Literature specifically addressing arrest and recidivism rates tends to support the idea that since deinstitutionalization there has been increased involvement of the mentally ill with the criminal justice system. Contributing factors which often lead to arrest are also supportive, since these are resultant of the deinstitutionalization movement. Differences in dispositions for offenses reflect both the complexity in appropriately handling this population, as well as the difficulty in accurately tracking their criminality. Suggestions were made regarding future action to reduce the propensity for involvement of the mentally ill with the criminal justice system.

TABLE OF CONTENTS

CHAPTER 1

THE DEINSTITUTIONALIZATION AND COMMUNITY MENTAL HEALTH MOVEMENTS

History

"Deinstitutionalization" is the term used to describe the process of discharging persons diagnosed as mentally ill from psychiatric hospitals, transferring their care to a community setting. The related "community mental health movement" is the development and expansion of facilities in the community to which care for these discharged persons was to be transferred. To understand these processes, it is necessary to review literature from the time periods of their conceptualization and development along with current writings. Recent literature describes the movements in retrospect, as well as the present status and implications.

Initiation of the Movements

The initiation of deinstitutionalization can be traced back to 1955 (Merton & Nesbit, 1971), at which time it began slowly, escalating in the 1960s and 1970s. Influences of this time were an increased public awareness of the often substandard conditions of many hospitals and the beginnings of change in attitude toward the mentally

disordered.

Torrey (1988) described 1961 as a "watershed year for psychiatric services in the United States" (p. 97). The Joint Commission for Mental Illness and Health had issued a report proposing that community mental health centers become the primary providers of care for the mentally ill, rather than state mental hospitals. Published literature supported this idea, along with changes in attitude toward the mentally ill. Often credited with promoting new attitudes was Szasz (1974), who wrote an essay and two editions of a book entitled "The Myth of Mental Illness." First published in 1961, Szasz in this writing rejected the idea of mental illness. This rejection was less accepted by the psychiatric community than the public at large (Dinitz, Dynes, & Clarke, 1969). Szasz (1974) stated, "If there is no such thing as mental illness, there can be no hospitalization, treatment or cure for it" (p. 267). Undoubtedly influential with proponents of deinstitutionalization was his comment "There is no medical, moral, or legal justification for involuntary psychiatric interventions. They are crimes against humanity" (p. 267).

The Influence of Kennedy

John F. Kennedy, in 1963, delivered an address, "Mental Health and Mental Retardation," which profoundly affected

the future of the deinstitutionalization and community mental health movements. He described mental illness and mental retardation as being among the most critical health problems. In this "bold new approach" (p. 463), prevention was to be an important focus. The causes of mental illness and mental retardation were to be sought and eradicated. Kennedy called for an increase in knowledge, research and training for the mental health field. Very important in these mandates was his proposition for increasing the community based services to the mentally disabled. Kennedy's stated goal was the reduction of the number of patients in custodial care by half within ten to twenty years. He specifically stated, "We must act . . . to reduce, over a number of years, and by the hundreds of thousands, the persons confined to these institutions" (p. 459). He called for the development of community mental health centers and recommended that grants for the construction of the centers begin in 1965.

In 1969, Dinitz, Dynes, and Clarke reported that most of Kennedy's recommendations had been enacted by Congress and that many programs were already in operation. It can be verified that as early as 1966 these programs and processes were in action. The May 1966 issue of the NAMH Reporter is replete with information concerning the construction and development of community mental health centers, plans to discharge non-voluntary patients from

custodial care and training programs for mental health workers.

Mechanic (1969) called the prioritizing of community mental health treatment a tremendously important decision which emphasized that "mental illness is not inherently different from the larger range of psychological difficulties in the community" (p. 60). This change in ideology was described by Heller and Monahan (1977): "the community mental health movement is marked by a call for a preventative instead of an exclusively treatment orientation" (p. 111).

Developments through Political Administrations

Support for community mental health programs has varied significantly with political administrations. Community mental health centers continued to expand during the Johnson years. The Nixon administration, however, began to question the federal funding of these programs. The Carter administration was more supportive of mental health issues and created the Commission on Mental Health. This resulted in an act intended to maintain and expand community mental health services (Humphreys & Rappaport, 1993).

The goals to improve mental health services were not enacted by the Reagan administration. At this time the Block Grant System was established, which shifted the responsibility to the states for the use of federal funds,

as well as reduced the number of required services to be provided by the centers and the funding they received (Hadley & Culhane, 1993). When Hadley and Culhane tracked 761 federally funded community mental health centers to assess their status 10 years after the Block Grant financing system was established, they found the system to have largely survived the federal cutbacks and funding changes.

During the Reagan and Bush administrations there was less focus on the problems of the mentally ill and more focus on substance abuse programs (Humphreys & Rappaport, 1993). President Clinton, however, eliminated the majority of jobs at the office of National Drug Control within three weeks of taking office (Humphreys & Rappaport, 1993). The future of mental health policy is unclear.

Consequences

No Improvement in Status

The general consensus is that the deinstitutionalization movement has not been successful. Merton and Nisbet (1971) pointed out that the decline in mental hospital population was not a reflection of a decrease in the prevalence of mental illness. It was a reflection of changes in policy, facilities and techniques. Scull (1981) claimed that the change had been the packaging of the misery of the mentally ill. Being granted the right to

be free from organized interference in their lives often meant the denial of the right to care and attention.

A contemporary example is that with an increasingly older population there are more cases of senile dementia. Although one of the goals of mental health centers was to address these needs, services do not exist in many communities (Atchley, 1991). Persons with senile dementia are unresponsive to therapy provided by mental health centers and are not disturbed enough to qualify for hospitalization. The latter has risen from changes in laws making it more difficult to commit a person to a psychiatric facility. The laws are not working as was the intention for them, which was to protect the rights of these individuals. (Torrey, 1988)

Insufficient Development of Services

It appears that the development of services to mentally ill persons has not been sufficient. French (1987) called deinstitutionalization a flawed movement and attributes its failure to lack of services by the community mental health system to socially marginal and impoverished clients. Stein (1986) explained that although there had been out-placement of patients from hospitals, in many communities, there had not been a development of a comprehensive and integrated system of community based care. In Florida, Becker (1993) found that although the mental hospital

services are inadequate, there is a waiting list for admission. He stated, "this is a strong indication that comparable community alternatives do not exist" (p. 106). Apparently this situation is similar throughout the country (Wilson, 1993).

Unrealistic Goals

A possible weakness of these movements may be what can be seen in retrospect as unrealistic goals. Hersen, Kazdin, and Bellack (1983) pointed out that the community mental health movement began a meteoric rise when idealism and funding were high. The hopes were to transform the entire system. This dramatically changed by the end of the Vietnam era. Along with funding cuts was a shattering of the earlier idealism. It became apparent that prevention was easier theoretically than practically and there was considerable difference in the ideas of community members and political leaders about their needs than that of "academically trained professionals" (p. 699).

Criminal Justice System Involvement

It has been suggested that since the deinstitutionalization movement there has been an increase in the involvement of the mentally ill with the criminal justice system. French (1987) claimed that while there are fewer institutionalized psychiatric patients, there has been

an overcrowding of jails and prisons. He indicated that the criminal justice system often replaces the mental health system as the primary care provider for the homeless mentally ill. According to Torrey (1988) there has also been a sharp increase in mentally ill persons charged with minor crimes in order to "get them off the streets" (p. 13). Research addressing this issue will be presented in the following chapters.

CHAPTER 2

CRIMINALITY OF THE MENTALLY ILL

One of the consequences of deinstitutionalization may be the criminalization of the mentally ill. This review is concerned with literature addressing whether there has been an increase in the involvement of the mentally ill with the criminal justice system since the deinstitutionalization movement. The mentally ill offenders would probably have been hospitalized before the changes in legislation regarding commitment and mental health services. This review will focus on adults whose diagnoses would have placed them in the mentally ill group. These are people who have interacted with the criminal justice system instead of, or in addition to, the mental health system.

Populations of Psychiatric Hospitals Versus Prisons

Since deinstitutionalization, there are more mentally ill persons in jails and prisons (Palermo, Gumz, & Liska, 1992). As the population of psychiatric hospitals decreased, the populations of jails and prisons have increased (Palermo, Smith, & Liska, 1991a). Reviewing several decades, Palermo, Smith, and Liska (1991a) consistently found an inverse relationship between the two populations. However, this relationship was not supported

by Adler (1983). Her study was flawed by the fact that her staff was denied access to inmates who were considered too violent, irrational or were exhibiting grossly bizarre behavior. Had these subjects been included, the results might have been quite different.

Arrest Rates

While early studies of the criminality rate of the mentally ill did not reveal differences from the general population, more recent studies suggest a much higher rate among the mentally ill (Adler, 1983; Mulvey, Blumstein, & Cohen, 1986; Palermo, Gumz, & Liska, 1992). These studies began as early as the 1920s and continue to the present. Although all studies do not agree, the increase appears to have followed the deinstitutionalization movement.

Many of the studies were performed within an approximate decade of the release of many patients from psychiatric hospitals. The following studies are often cited in literature and appear representative of the time period. Durbin, Pasewark, and Albers (1977) found no difference in arrest rates of released psychiatric patients when compared with the general population. The research of Zitrin, Hardesty, Burdock, and Drossman (1976) revealed that released mental patients had higher arrest rates than the general population (total arrest rates for major crimes were 25.52% compared to 5.13%). Sosowsky (1978) found

three times more arrests for non-violent crimes during the post-deinstitutionalization period, three and one-half times more arrests for violent crimes and one and one-half times more arrests for violent crimes which had the potential for harm. Sosowsky reported that in comparison to the general population, the mentally ill offenders, "incidence of arrest for criminal behavior, including violent offenses is markedly higher than the corresponding incidence of arrest in their community ($p < .001$)" (p. 40). In a later study, Sosowsky (1980) compared arrest rates of released mental patients with prior arrest records to those who had never been arrested. Fifty-six percent of the patients with arrest histories were rearrested (correlation of .272 with prearrest record). However, 24% of the patients without prior arrest histories were charged with crimes after release. Fifty-three percent of the arrests for the latter group occurred "within 19 months after discharge" (p. 1603).

More recently Teplin and Pruett (1992) found that persons considered mentally disordered to have an arrest rate almost double that of the non-mentally disordered (46.7% vs 27.9%). Current studies addressing the criminality rates of the mentally ill are largely literature reviews of past studies. Palermo, Gumz, and Liska (1992) specifically compared studies of mental illness and criminal behavior from before and after the deinstitutionalization

period. This comparison revealed that arrests of this population have increased.

Recidivism

There are conflicting findings regarding the criminal recidivism of the mentally ill. Jones, Gallagher, Kelley, and Arvanites (1992) found mentally disordered offenders to have more total convictions than non-mentally disordered offenders. No differences were found by Ashford (1988) or Hodgins and Cote (1993). In a study by Silver, Cohen, and Spodak (1989) mentally disordered offenders were arrested sooner after release from prison than non-mentally disordered offenders.

Feder (1991) was able to explore several concepts in an 18-month follow-up of released prisoners. Mentally ill offenders were no more likely to have a prior arrest history. Approximately equal proportions of mentally ill and non-mentally ill offenders were rearrested after their release from prison (64% vs 60%). Mentally ill offenders were less likely to have parole revocations. When this did occur, there were significant differences in reason. Non-mentally ill offenders were more likely to have revocations for rearrest or absconding, while the mentally ill offenders were more likely to have technical violations. During the study period, 36% of the mentally ill offender group and 42% of the non-mentally ill offenders were

jailed for new arrests or revocations of parole. Twenty-seven percent of the first group and 32% of the latter received additional jail time for new convictions.

Types of Crime

It has been reported that the mentally ill are more likely to be arrested for minor crimes than serious offenses (Ashford, 1988; Palermo, Gumz, & Liska, 1992). There are conflicting findings regarding violent crime by the mentally ill. Some studies have found this group to be no more violent than the general population (Ashford, 1988; Hodgins & Cote, 1993; Palermo, Gumz, & Liska, 1992). Others have found them to be more violent (Feder, 1991; Jones, et al., 1992; Lindqvist & Allebeck, 1990). Jones, et al., (1992), reported that 78% of recidivist offenders had a record of violence, most often directed toward another person.

Diagnosis and Crime

Association of diagnosis with crime has been addressed. In a study of persons diagnosed with antisocial personality disorder (APD), Harris, Rice, and Cormier (1991) found that 77% committed violent crime subsequent to an instant offense. Mentally disordered inmates with co-occurring APD were found to have more total convictions and more non-violent convictions, but equal violent offense convictions in comparison to non-APD disordered inmates

(Hodgins & Cote, 1993). Palermo, Smith, and Liska (1991a) claimed that antisocial personality disorder with co-occurring substance abuse is often associated with criminal offenses.

Palermo, Smith, and Liska (1991a) also claimed "there is a high representation of chronic schizophrenia" (p. 53) in mentally ill offenders. In Sweden, Lindqvist and Allebeck (1990) found that males diagnosed with schizophrenia did not commit more crimes than that expected in the general male population. Although the actual numbers were small, females had a criminal rate double that of the general female population. Violent crimes were found to be four times more frequent among those diagnosed with schizophrenia than the general population.

Yesavage et al. (1986) reviewed readmissions of subjects who had been admitted to a psychiatric hospital having been judged non-responsible for their criminal acts. Patients diagnosed as mentally retarded or with personality disorders had higher violence rates at readmission than patients with other diagnoses.

Compared to Insanity Acquitees

Maeder (1985) described people found not guilty by reason of insanity as mentally ill, but held non-responsible for their crimes. They are, however, committed to psychiatric facilities. It appears that this population

may differ characteristically from the typical mentally disordered offender. In a study by Silver, Cohen, and Spodak (1989) the acquitees were older, more educated, more stable and composed of fewer minorities. The mentally disordered offenders had similar histories of hospitalization, but had poorer functioning and higher arrest rates than the acquitees. There were fewer murders and more people arrested for property offenses in the mentally disordered offender group.

These authors followed groups of insanity acquitees, mentally disordered offenders transferred to psychiatric hospitals during their imprisonment, and paroled convicted felons. As compared to the other groups, the mentally disordered had "higher unemployment rates, worse overall functioning, more rehospitalizations and were rearrested sooner after release from prison than the other two groups" (p. 398).

CHAPTER 3

FACTORS LEADING TO ARREST

There are a number of factors which may lead the mentally ill to become involved with the criminal justice system.

Behavior Control

Mentally ill persons are often arrested for exhibiting behavior in the community which must be controlled (Adler, 1983; Belcher, 1988; Hoehne, 1985; Teplin & Pruett, 1992). Teplin and Pruett (1992) found that arrest was often the only means of controlling a situation. Arrests took place when persons were not sufficiently mentally disordered to be admitted to the hospital, but were too obvious in their disorder to be ignored. People exhibiting less overt or more predictable, consistent behavior were not likely to be arrested. Belcher (1988) found this group not be higher functioning, but less overt in their mental disorder. If police intervention is required with the latter group, it is more likely to be handled by informal means, rather than by arrest (Teplin & Pruett, 1992).

Problems with Hospitalization

To control deviant behavior, arrest often takes place when hospitalization is not an option. This stems from the changes in commitment laws making it more difficult to involuntarily hospitalize a person (Adler, 1983; Morse, 1983; Weideranders, 1992). Teplin and Pruett (1992) found hospitalization rarely initiated in their study. In fact, the police often obtained signed complaints from third parties to facilitate arrest even when hospitalization was deemed appropriate. This was to ensure an available alternative if the hospital would not accept the person for admission. In addition to more stringent commitment laws, there is often a problem admitting a patient who is deemed too violent or disruptive by hospital staff (Brahams & Weller, 1986; Teplin & Pruett, 1992). Persons with any pending charges are also often ineligible for admission (Teplin & Pruett, 1992).

Support

The related factors of community and familial support are significant in the potential of the mentally ill to become involved with the criminal justice system. Mentally ill offenders are less likely to have community support (Ashford, 1988; Feder, 1991). Persons with family support are the most likely to adjust successfully in the community, and do not tend to get involved with the criminal justice

system (Belcher, 1988; Hoehne, 1985). They are often brought by their families to mental health facilities for aftercare.

Aftercare

Pursuance of aftercare is a significant factor in successful community adjustment (Belcher, 1988; Hoehne, 1985). Wiederanders (1992) found patients released from psychiatric hospitals with the condition to pursue aftercare had significantly lower arrest rates in the community than the non-conditionally released patients, who were often arrested for similar behaviors to their instant offense.

Living Arrangements

Residents of half-way houses often have little supervision, aid or encouragement (Hoehne, 1985). Although they may not be overtly deviant enough to warrant community attention, some do encounter the criminal justice system. Regarding his study of this group, Hoehne (1985) stated, "Many found out that they could sell their medication as 'downers' to the street drug people . . . some stumbled into legal difficulties they could not comprehend" (p. 40). Discontent with living arrangements can even lead to encounters with the criminal justice system. Former patients have committed arson in order to express a desire to change the location of their care (Geller, 1984).

Homelessness has been found to be a significant factor in the potential of the mentally ill to become involved with the criminal justice system (Belcher, 1988; Brahams & Weller, 1986; Hoehne, 1985; Torrey, 1988). This is often compounded by other factors. In addition to being homeless, these people often have histories of biologically based mental illness such as schizophrenia and major affective disorders (Belcher, 1988; Jones, et al., 1992; Palermo, Gumz, & Liska, 1992). Additionally these people have no family or community support and do not participate in aftercare treatment (Belcher, 1988; Hoehne, 1985).

This group tends to wander the community aimlessly (Belcher, 1988; Brahams & Weller, 1986; Hoehne, 1985). Brahams and Weller (1986) indicated that vagrancy and destitution often result in criminal convictions. Many of these people are repeatedly arrested for misdemeanors, according to Hoehne (1985). He stated, "The courts are clogged with arrest cases from this group" (p. 40).

Substance Abuse

The mentally ill are an "extremely vulnerable, high risk group for substance abuse" (Drake, Alterman, & Rosenberg, 1993, p. 187). If the mentally ill have substance abuse problems, they are more likely to be arrested (Hoehne, 1985; Teplin, & Pruett, 1992). The

dually disordered are among the majority of the new prisoner population (Pepper, 1993). Cutler (1993) suggested psychiatric patients are "rescued from the relative comfort of hallucinations and delusions" (p. 194) by prescribed psychotropic drugs. Faced with problems of reality, they turn to alcohol and street drugs. The use of these substances may lead to an increase in mentally disordered thinking. The result could be violence or a criminal act (Hoehne, 1986; Pepper, 1993). Jones, et al. (1992) found 71% of a recidivist sample having substance abuse problems in addition to psychiatric disorders. In a study of recidivism of persons committed to a psychiatric hospital for criminal acts, Yesavage, et al. (1986) stated "alcohol ingestion was associated with a significant number of crimes across the diagnostic categories" (p. 466). Nineteen percent of the violent crimes had an association with alcohol, for recidivists there was a 35% association of alcohol with crime.

The results of some studies have differed in regard to this issue. Abram and Teplin (1990), in a carefully controlled study, did not find a significant correlation between violent crime, mental illness and substance abuse. Feder (1991) found non-mentally disordered offenders to have a significantly higher number of drug related arrests than mentally disordered offenders.

CHAPTER 4

OFFENSE DISPOSITIONS

Conflicting Approaches

When a mentally ill person is arrested, there are conflicting views on the appropriate dispositions for their offenses (Heller & Monahan, 1977; Morse, 1983). Their rights come into question as well as disagreement over whether they should be treated or punished. Thus, "the mentally disordered offender is the 'hot potato' who is tossed back and forth as each side alternates it victories" (Heller & Monahan, 1977, p. 166). These authors have described two approaches in handling mentally disordered offenders. One is to divert them from prison, where it is thought they do not belong, into mental hospitals. The other approach is to claim their rights are being violated in mental hospitals and that they are better protected in prison.

Overlapping Jurisdiction

Much deviant conduct is under jurisdiction of both the mental health and criminal justice systems (Morse, 1983). An assault may be viewed as a misdemeanor, a sign of mental illness, or both. In the case of serious crime, such as murder, a person may be tried with an insanity

defense; Morse (1983) claimed this is rare. They may be diverted from the criminal justice system into mental health treatment. The person may be prosecuted without regard to their mental illness and found guilty, with no subsequent mental health treatment while imprisoned (Heller & Monahan, 1977; Morse, 1983). Apparently the handling of each case is on a situational basis. These offenders may present a wide range of symptoms, resulting in frustration of court judges in rendering "just and effective dispositions" (Whitmer, 1993, p. 217). While the courts may realize they cannot provide proper services, the community mental health center staff to which they may refer often make the same claim (Jones, et al., 1992; Whitmer, 1993).

Disposition Differences

Feder (1991) identified trends in the handling of arrests for the mentally ill. For minor crimes the mentally ill offenders were more likely to have the charges dropped than the non-mentally ill offenders. If convicted of these or other non-violent offenses, the mentally ill were less likely to be sentenced to jail time, being ordered to treatment instead. There was no difference in disposition between the groups for violent arrests.

When incarcerated, mentally ill offenders have poorer prison adjustment and are less likely to be paroled than non-mentally ill offenders (Feder, 1991). In her study,

more than one out of five of the mentally ill offenders were committed to psychiatric facilities straight from prison. Ninety percent of this group were released into the community during the eighteen months of her study.

CHAPTER 5

DISCUSSION

Summary

The deinstitutionalization movement has been successful in terms of releasing patients previously confined to psychiatric institutions and preventing persons from being unnecessarily hospitalized. There have been unfortunate consequences. Hospitalization is often not available when it is needed. There appears to be a lack of appropriate and available community mental health services.

Although research results differ, there does appear to be an increase in the interaction of the mentally ill with the criminal justice system since the deinstitutionalization movement. Reviews of prior studies of arrest rates from before and after this movement are in agreement that these rates have increased. This is further confirmed by studies of the interaction of the mentally ill with the criminal justice system since the implementation of the movement.

Some researchers have found that mentally ill offenders are more likely to be misdemeanants, others that they have an increased rate of violent crime. No specific conclusion can be drawn in regard to non-violent felonies. Palermo, Gumz, and Liska (1992) attributed conflicting

and contradictory findings to "differing assessment tools, data gathering procedures, sample and analyses of data" (p. 54). Since there are conflicting dispositions for offenses with the mentally ill, this could affect the results of studies addressing arrest rates and recidivism. Arrest rates may not reveal the total involvement of this population with the criminal justice system. Teplin and Pruett (1992) found most of the mentally ill in their study handled by informal means.

It is clear that the propensity for the mentally ill to become involved with the criminal justice system has increased. This system often takes responsibility for controlling behavior of this group. People with overtly deviant behavior are more often arrested than those whose mental disorder is less apparent. It appears arrest often takes place because the psychiatric commitment procedures have become so stringent and hospitals are often reluctant to admit violent patients.

While it may not be that the mere presence of mental disorder increases the potential to offend, accompanying factors makes this more likely. Lack of familial ties, community support and treatment increase this potential. Inappropriate living arrangements and substance abuse are important as well. Homelessness, which often includes all the other factors often leads to interaction with the criminal justice system.

Future Action

In order to assist the mentally ill and reduce their involvement with the criminal justice system, specific issues need to be addressed.

Realistic Attitudes

Mechanic (1969) described the attitude in the 1960s as one which viewed mental illness as not inherently different from general psychological difficulties in the community. As the realities of community adjustment for this population have become apparent, this view is problematic. Mental illness is not intensification of unpleasant normal emotions. Delusions and hallucinations are not part of the common experience (Brahams & Weller, 1986). The belief that these and other disorders can be managed without supervision in the community is, according to Brahams and Weller (1986), "hopelessly naive and may lead to dangerous and tragic consequences both for the patient and for the public at large" (p. 51).

Legislation Changes

Changes in legislation regarding hospitalization are needed. Ideally these changes could address the sensitive topic of involuntary commitment with provisions that would prevent abuse of the laws. Belcher and Blank (1989-90) have proposed the creation of an agency to monitor the

treatment and commitment of mentally ill people. The agency should be a separate entity from the existing governmental or mental health agencies. Having access to psychiatric and legal records, this agency could ensure that patients who needed hospitalization and care would not inappropriately be left in the streets. Belcher and Blank (1989-90) stated, "Specifically, it could investigate instances where the client's rights were protected, but the client's needs for inpatient treatment was ignored" (p. 112). This agency could address and present needed changes in legislation.

Case Management

Active case management appears to be a possible deterrent to the involvement of the mentally ill with the criminal justice system (Test, 1981). The mentally ill person is in need of structured support as he or she attempts to adjust to community living (Belcher, 1988). Test (1981) suggested that aid in securing and maintaining housing, as well as assistance and instruction in basic living skills and needs (food, clothing, personal care) be provided. Readily available mental health services, particularly crisis intervention, is important. Test stressed that important in delivery of these services is an individualized approach and an emphasis on continuity of care. There is a need for a greater involvement of

the mental health worker in following these clients (Belcher, 1988; Test, 1981).

Systems Integration

There is a need for integration of the correctional and mental health systems (MacKain & Streveler, 1990; Palermo, Smith, & Liska, 1991b). If a mentally disordered prisoner requires treatment, it should be provided (Morse, 1983). In addition to attention to their psychiatric diagnoses, these offenders need assistance to enable them to function in the community upon their release (MacKain & Streveler, 1990). MacKain and Streveler have suggested that the correctional system is able to compel mentally ill individuals to receive treatment and is well equipped to keep track of them.

Research has shown that integration of the systems can be effective. Looking specifically at Milwaukee, Palermo, Smith, and Liska (1991b) found the previously mentioned negative correlation between the population of jails and prisons and mental hospitals was not supported. The authors attributed this to the fact that more than ten years ago, a forensic unit was established on the premises of the courthouse and jail. This unit is staffed by psychiatric professionals and is "easily accessible and always available to perform examinations for legal competency and presentencing" (p. 213). Psychiatric reports

are prepared upon request and presented to the courts, thereby providing information about the client and expediting transfer to a mental health facility if necessary. Psychiatric evaluations for inmates exhibiting behavior disturbances are available upon request of jail personnel. This leads to earlier detection of problems and again more expedient transfer to treatment if needed.

The criminal justice system is in need of more information regarding the mentally ill. Palermo, Smith, and Liska (1991b), suggested a mental health services data bank be made available to the corrections system. Greater knowledge of the nature of substance abuse and psychiatric disorders would enable the authorities in the criminal justice system to make better decisions in regard to mentally disordered offenders (Pepper, 1993).

Future Research

Future research could benefit from an integration of the criminal justice and mental health systems. Since the criminal justice system may be able to better track these individuals, MacKain and Streveler (1990) suggested, "longitudinal studies of mentally ill offenders and parolees may therefore be possible, whereas such investigations are not usually possible with the transitory, noncriminal mentally ill population" (p. 515). This population may be difficult to effectively study. Methods of research

could be compared in order to identify which yields the most reliable results. Once identified these methods could be applied to addressing topics where previous research results conflicted. Then perhaps it could be discovered whether the mentally ill are more likely to commit minor crimes or more serious, violent crime. Future research should also be concerned with further identifying factors that increase the propensity of the mentally ill to interact with the criminal justice system. Alternative means of handling these offenders should also be investigated. Methods of treatment that reduce the propensity to become involved with the criminal justice system should be addressed. The implementation of these suggestions could lead to a decrease in the involvement of the mentally ill with the criminal justice system. Their rights would also be more protected, and in the cases of crimes against others and in terms of societal burden, the rights of others would be considered and protected as well. These people, if provided with the appropriate care, would be able to live with more dignity and safety. Society as a whole would benefit.

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