The Criminalization Hypothesis:
The Relationship Between Deinstitutionalization and the
Increased Prevalence of Individuals with Mental Illness in Correctional Systems

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ABSTRACT

There are one tenth the number of psychiatric beds today as there were 50 years ago, while the population of the United States has nearly doubled. A combination of socio-cultural and political forces led to deinstitutionalization, creating an exodus of individuals with mental illness from state hospitals into society. Although the number of incarcerated individuals quadrupled between 1980 and 2000, there were no national statistics on the prevalence of mental illness within correctional systems until 1999. Despite great speculation for the criminalization hypothesis, backed up by fragmented research with less than ideal methodology, evidence suggests a relationship between deinstitutionalization and an increased prevalence of individuals with mental illness in correctional systems. This relationship appears most conclusive among homeless individuals with mental illness. Research lags in quantifying the influence of various factors on criminalizing individuals who, in earlier times, would otherwise have received psychiatric treatment in a hospital. Regardless of the political factors and social climate influencing the criminalization hypothesis, it appears jails and prisons have become the most enduring asylums.
INTRODUCTION AND STATEMENT OF THE TOPIC

In his comparative study of mental hospitals and prison populations, Penrose (1939) suggested society controls its socially undesirable members in two ways. The first is incarceration after a legal infraction occurs, fulfilling the functions of retribution and deterrence. The second is the more favorable option of institutionalization, as society can detain an undesirable individual, whether he or she committed an offense or not, thus preemptively sparing the community misfortune. Penrose stated, "Indeed, in the earliest asylums, patients were often confined, like prisoners, in chains" (1939, p. 8). Care for individuals with mental illness in the middle 19th century United States exemplified this claim. Dorothea Dix, a prominent mental health reformer of the time, outraged by prison conditions for individuals with mental illness, made this address to the United States Congress on June 23, 1848:

I have myself seen more than nine thousand idiots, epileptics, and insane, in these United States, destitute of appropriate care and protection . . . bound with galling chains, bowed beneath fetters and heavy iron balls, attached to drag-chains, lacerated with ropes, scourged with rods, and terrified beneath storms of profane execrations and cruel blows . . . now abandoned to the most loathsome necessities, or subject to the vilest and most outrageous violations. (as cited in Brady, 1975, p. 145)

The federal government proved unwilling to fund a national mental health program, so Dorothea Dix took her plea to individual states, resulting in 28 of 33 states opening 32 public mental health hospitals, beginning the mental health reform movement (Cutler, Bigelow, & McFarland, 1992). The expansion of mental health beds, from under 150,000 around the turn of the 20th century to
nearly 560,000 by the middle 1950s, evidenced the success of institutionalization (Bassuk & Gerson, 1978).

By the middle of the 20th century, bloated institutions strained at the seams and the pendulum began to swing back, bringing the era of deinstitutionalization continuing though today. Although there were revelations in antipsychotic medications, the literature stressed the influence of the socio-cultural and political zeitgeist as the impetus for deinstitutionalization (Abramson, 1972; Estroff, 1981; Klerman, 1977; Scull, 1981). Arguments for deinstitutionalization and a shift toward community care varied greatly. The movement received remarkable support from across the political spectrum. Fiscal conservatives saw an opportunity to cut budgets by transferring or discharging patients, shifting the fiscal burden to the federally funded programs of Medicare or Social Security (Klerman, 1977). Civil libertarians, appalled by the lack of treatment in institutions felt, “The mere absence of the deforming, dehumanizing pressure of life in a mental hospital would itself represent a profoundly positive development” (Scull, 1981, p. 8). Other pressures for deinstitutionalization included the fad of antipsychiatry, thoughts that institutions fostered collectivist and dependent values antithetical to American values of autonomy and independence, and increased willingness by the judiciary to intervene in operations of mental institutions and prisons (Estroff, 1981; Scull, 1981). In contrast to the good intentions that drove mental health reform a century earlier, consensus determined institutions had become inhumane and ineffective.
The movement of individuals with mental illness from institutions to the community intended to promote societal integration, nurture social skills, and foster independence, but nothing was done to diminish the social stigma of mental illness and its impact on former patients (Estroff, 1981; Ewalt, 1961; Gilligan, 2001; Klerman, 1977; Scull, 1981; Whitmer, 1980). Given society’s propensity for keeping the socially undesirable from the public view, Penrose argued, “As a general rule, if the prison services are extensive, the asylum population is relatively small and the reverse also tends to be true” (1939, p. 3). Teplin (1984) coined the term “criminalization hypothesis” to describe the processing of mentally disordered behavior within the criminal justice system, as opposed to the mental health system, with particular concern for those committing low level or nuisance offenses. This paper proposes to explore research examining the criminalization hypothesis, recent trends, and the influence of combined homelessness and mental illness on the criminalization hypothesis today.
CRITICAL REVIEW OF THE LITERATURE

The Beginning of Deinstitutionalization

Congress authorized the Mental Health Study Act of 1955 to explore the problems of institutionalization (Ewalt, 1961). Their impetus was the growing burden of individuals with mental illness occupying 47% of the nation’s hospital beds, which cost taxpayers more than $1 billion per year, and was increasing by $100 million per year. The Mental Health Study act resulted in the 1961 Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health to determine a resolution, laying the groundwork for the Community Mental Health Act that sparked the substance of deinstitutionalization (Gilligan, 2001). The Commission repeated concerns about societal rejection and stigmatization of individuals with mental illness, and the implications for outpatient treatment (Ewalt, 1961). Their evidence for this opinion included ballooning hospital populations, a lack of active treatment by the majority of state hospitals, the marginal investment in dollars and personnel per mental patient, and toleration of abysmal institutional conditions. The Commission argued:

Society has organized itself out of a primary concern for the 99 [out of 100] who behave in tolerable fashion or are cast in such circumstances that they do not disturb the peace of their fellow men sufficiently to acquire the mental patient label. (Ewalt, 1961, p. 87)

To reverse the burgeoning trend of institutionalization, the Commission concluded the need for an increase in outpatient community mental health centers, an increase in the number of mental health professionals, and more
long-term research on the etiology and treatment of mental illness. Though not explicitly emphasized in the literature, extensive discussion of two other conclusions – changing public attitudes toward mental illness, and tripling funding for public mental health services within 10 years – seemed to also imply particular importance in this transition.

Laws implementing deinstitutionalization led to a narrowing of civil commitment standards, resulting in substantial increases in civil liberties for individuals with mental illness. Abramson (1972) discussed implications of the Lanterman-Petris-Short Act (LPS) on civil commitment processes in California. After its passage, 72-hour commitment was limited to instances where an individual posed a danger to self or others, or was gravely disabled, as evidenced by inability to provide food, clothing, or shelter for him or herself. In addition to adding stringent guidelines on the length and justification required for commitment, Abramson indicated that the act effectively eliminated a previous standard of inherent need for treatment as sufficient criterion for commitment. Changes to civil commitment laws provided individuals with mental illness more power to refuse treatment and resulted in immense success in the Commission’s goal to transfer patients from state hospital custody to the community. Psychiatric beds decreased from approximately: 559,000 in 1955 (Quanbeck, Frye, & Altshuler, 2003), to 426,300 in 1967, to 248,500 in 1973 (Taube, 1975), to 98,600 in 1990, to 54,000 in 2000 (NRI, 2004). Today, the U.S. has one tenth
the number of psychiatric beds than were available in 1955, while the population has nearly doubled.

The process of deinstitutionalization occurred in stages. First, state hospitals transferred elderly patients with mental illness to nursing homes, shifting the fiscal burden from states to federally funded Medicare (Bassuk & Gerson, 1978; Klerman, 1977). Second, the rapid discharge of patients hospitalized for acute psychiatric difficulties coincided with a new focus on shorter hospitalization episodes; yearly admissions doubled between 1955 and 1972, as the number of patients readmitted within one year grew from approximately 30% in 1955, to 64% by 1972 (Bassuk & Gerson, 1978). Third, deinstitutionalization gained momentum, even as hospital populations dwindled to institutionalized patients suffering from chronic mental illness. In the late 1960s, most states began to discharge chronically ill patients, despite the controversy generated, and minimal research supporting the prudence of said policy (Klerman, 1977). The release of institutionalized patients with chronic mental illness and increase in revolving door readmissions created concerns about treatment following discharge.

Some researchers speculated that former patients went without needed outpatient care after release. Whitmer (1980) conducted a study of 500 defendants, half charged with misdemeanors and half with felonies. Some had experienced arrest, but few ever served prison time. All had an inpatient history, averaging three prior hospitalizations, and were in need of psychiatric treatment.
He found 60% had no outpatient treatment history and 94% were without any outpatient treatment upon arrest. He argued that, “The discharged patient who is most in need of these services, but least able to secure them for himself, is the first patient to be lost” and referred to these individuals as “forfeited patients” (1980, p. 67). Some speculated that the marginalized chronically mentally ill patient had become the marginalized chronically mentally ill societal outcast (Estroff, 1981; Klerman, 1977; Scull, 1981; Whitmer, 1980). In addition to legal changes, Whitmer (1980) cited clinical factors contributing to this phenomenon including unemployment, lack of medication compliance, disinterest in outpatient treatment, and lack of a significant social network. Such an individual would commonly refuse residential care because:

The programs take too much of his income, threaten him with pernicious control over his long-disputed autonomy, and deprive him of the protection of social withdrawal allowed in an isolated hotel room . . . . Thus the ex-patient separated from the mental health system continues in his marginal lifestyle until an acute psychotic decompensation compels social intervention. (Whitmer, 1980, pp. 67-68)

Deinstitutionalization was immensely successful in removing patients from state hospitals, though early signs signaled that some were not receiving the Commission’s anticipated outpatient care. The Commission’s two emphasized needs of substantial increases in funding and changes in public perception failed to materialize during deinstitutionalization and exacerbated this concern.

Regarding funding, in 1961, the Commission recommended tripling public mental health dollars over 10 years to establish outpatient mental health centers, covering the exodus of mental health patients (Ewalt, 1961). Bassuk and Gerson
(1978) cited three factors inhibiting proper funding during this process. First, Medicaid would not fund treatment for the non-elderly with mental illness hospitalized in centers exclusively treating mental illness (referred to as Institutions for Mental Diseases, or the IMD exclusion) including state hospitals, residential treatment centers, and halfway houses. IMDs overcame this obstacle by transferring elderly patients with mental illness into nursing homes, shifting funding demands to Medicare. Second, the $167.80 available monthly to former patients through Supplemental Security Income was not available to those living in group homes or halfway houses, providing incentive to take up residence in a nursing home or inner city hotel. Third, despite significant increases in psychiatric costs, Medicare’s $250 yearly cap on outpatient treatment, established in 1965, remained frozen for more than a decade. Further, federal funding for treatment of mental illness decreased since 1975, after factoring for inflation (Teplin, 1991). Limited federal funding and restrictive eligibility requirements suggested a greater emphasis on removing patients from state hospitals than on community treatment and integration strategies within the framework of deinstitutionalization.

The Commission’s concern of negative public perception of mental illness appears driven by two forces (Ewalt, 1961). First is the ill-conceived notion that mental illness connotes dangerousness. Second is societal discomfort with bizarre behavior. Deinstitutionalization did nothing to adequately ameliorate either issue. Steadman and Cocozza (1978) reported that society perceives
individuals with mental illness, but who are not criminally insane, as more
dangerous, harmful, violent, unpredictable, and mysterious than *most people*,
breeding reactions of fear and rejection. This perception, however, is
incongruent with the true propensity of violence for those with serious mental
illness. Monahan (1992) conducted a study assessing 10,000 individuals for
violent behavior over a one-year timespan. He found individuals with diagnoses
of bipolar, major depression, and schizophrenia exhibited base rates of violence
of 11.0%, 11.7%, and 12.7% respectively, far less than the rates of 24.6% for
those with alcohol abuse or dependence, or 34.7% for those with drug abuse or
dependence.

Societal rejection of ex-patients’ bizarre behavior, poor social functioning,
odd appearance, and lackluster economic productivity created a replication of
institutional back wards within welfare hotels in the community (Klerman, 1977).
NIMBYism (“Not In My Backyard”) contributed to failures in allocation of tax
revenues to fund group homes, drop-in centers, outpatient clinics, and other
facilities meant to promote community integration for ex-patients (Gilligan,
2001). Segregated from middle-class neighborhoods, discharged patients without
financial means were often sequestered to substandard housing in poorer
neighborhoods with a three-fold effect (Klerman, 1977). First, it inhibited social
integration as they took up residence in isolative hotel rooms. Second, it left
them vulnerable to victimization in unsafe neighborhoods. Third, it stymied
opportunity for society to challenge perceptions by effectively limiting contact
with this feared and rejected population, leaving existing stereotypes and biases to linger.

Based on society’s limited tolerance for mental illness and changes in commitment criteria, Abramson (1972) speculated that the premature release of those with mental illness into society would breed pressure to utilize sanctions of arrest and incarceration as a means of involuntarily detaining, or reinstitutionalizing, individuals with severe mental illness. Although California’s LPS act was viewed as analogous to the Magna Carta for those with mental illness, providing an increased right to refuse treatment and restricting civil commitment standards, Abramson speculated that the result was antithetical, making arrest the path of least resistance when these individuals experienced contact with law enforcement. Whereas societal disturbances originally resulted in hospitalization and psychiatric stabilization, they now more often led to arrest and a criminal record that could divert these individuals to jail rather than the hospital in the future, or be used as evidence to secure long-term hospitalization after repeated infractions. Abramson stated:

> It would indeed be ironic if the Magna Carta of the mentally ill in California led to their criminal stigmatization and incarceration in jails and prisons, where little or no mental health treatment is provided. Those who castigate institutional psychiatry for its present and past deficiencies may be quite ignorant of what occurs when mentally disordered patients are forced into the criminal justice system. (1972, p. 105)

Abramson’s concerns, the most frequently cited in the literature to initially speculate on deinstitutionalization’s effects, appear strikingly similar to those echoed by Penrose 30 years earlier: “Such people have to be confined, if
necessary against their wishes, to safeguard the interests of the rest of the community” (Penrose, 1939, p. 1). Namely, society will find a way to keep its *intolerables* out of the public eye, be it through mental hospitals or the correctional system.

*Early Findings – From the Hospital to Jail*

Initial research on the increased prevalence of those with mental illness in correctional systems was heavily speculative, provided mixed findings, and was frequently limited by poor research design or methodological flaws. Teplin (1983) conducted a comprehensive analysis of many research articles examining the validity of Abramson’s thesis of the criminalization of mentally disordered behavior. It was one of the finest examples of research at the time that, based on a critical review of empirical evidence, supported her criminalization hypothesis (Teplin, 1984). She explored this trend by examining studies that analyzed the arrest rates of former patients, explored evidence of mental illness in correctional systems, and determined the prevalence of mental health symptoms at time of arrest.

If the criminalization hypothesis were true, it would be necessary to show an increased prevalence of arrest among individuals with mental illness as the number of hospitalized individuals decreased. Correlation itself, however, is insufficient to prove the validity of the criminalization hypothesis. It cannot disprove the contention that mental illness itself is a predictor of culpable
criminality (Teplin, 1983). Thus, the argument that, greater numbers of former psychiatric patients roaming the streets would logically result in more arrests of individuals who, in an earlier time, were merely prevented from committing crime based on their hospitalized status. As previously determined, the late 1960s started the period when most states implemented more restrictive civil commitment statutes and began purging patients from state hospitals at an increased rate. Given this phenomenon, Steadman, Cocozza, and Melick (1978) and Steadman and colleagues (1984), explored arrest statistics of patients from 1968 through 1975 and 1978 respectively. Both studies examined patients in New York State allowing for a more valid comparison than studies conducted in different parts of the country at different times. Steadman, Cocozza, and Melick (1978) examined over 1,900 randomly selected patients released from state psychiatric facilities between 1968-1975, and Steadman and colleagues (1984) examined 400 randomly selected patients admitted to state psychiatric hospitals between 1968-1978. The studies revealed findings both supporting and opposing the criminalization hypothesis.

The evidence supporting the criminalization hypothesis lies in the incidence of arrest before hospitalization. To provide a baseline of prehospitalization arrest, it is helpful to include the findings of Brill and Malzberg (1962), who studied approximately 5,300 New York State psychiatric patients in 1947, before deinstitutionalization began. Over time, a trend emerged in the incidence of arrest before hospitalization for psychiatric patients in New York
State. In 1947, the rate was 15.0% (Brill & Malzberg, 1962), in 1968, it was between 31.9% and 36.7% (respectively, Steadman, Cocozza, & Melick, 1978; Steadman et al., 1984), in 1975, it was 40.0% (Steadman, Cocozza, & Melick, 1978), and in 1978, it was 51.0% (Steadman et al., 1984). At face value, the increased prevalence of arrest before hospitalization suggests support for the criminalization hypothesis. However, considering these studies used hospitalization as the sole determinant to classify subjects as mentally ill, in congruence with more restrictive civil commitment standards, the possibility of underestimating the criminalization of mental illness becomes greater. Due to sampling error, these studies excluded individuals who experienced mental illness in prison but were never hospitalized, and the non-hospitalized individuals with mental illness who, because of unnoticed symptoms, experienced arrest rather than hospitalization. This probability increased over time, as more restrictive civil commitment standards made hospitalization less tenable than jail, when problems occurred that brought these individuals to the attention of law enforcement.

Steadman, Cocozza, and Melick (1978) reported psychiatric patients were more likely to experience arrest. This could strengthen the criminalization hypothesis by concluding that individuals with mental illness are prone to decompensate in society, are subject to greater stress, and receive less comprehensive care in society than in the hospital. It could also weaken the criminalization hypothesis in that mental illness could correlate with criminality
without influencing sanity at the time of the offense. In this sense, individuals might suffer from mental illness and commit a crime, though not be actively mentally ill at the time of offense or suffer from symptoms that cloud their judgment, interfere with their ability to appreciate wrongfulness, or inhibit their control. For example, if an individual with treated schizophrenia robs a gas station due to antisocial tendencies or to feed an addiction, the criminal act is the product of something other than active Axis I symptoms.

Steadman, Cocozza, and Melick (1978) argued that the relationship between mental illness and arrest is misleading. In their study, most patients never experienced arrest, and arrest itself was much more likely to predict future arrest, as a smaller portion of individuals with mental illness who engaged in criminal activities were prone to repeated arrests. This seems the case, as nearly one fourth of their sample was hospitalized for substance abuse or personality disorder, with subsequent arrest rates of 18% and 28% respectively, whereas the arrest rate for all other patients ranged from 4% to 8%. Sampling bias created by the disproportionate arrest rates of individuals hospitalized for substance abuse or personality disorder weaken aforementioned findings that appear to support the criminalization hypothesis. Underestimation of the true arrest rate remains, however, created by the methodological flaw of sampling error excluding individuals with mental illness never hospitalized.

In spite of their findings of increased likelihood of arrest before hospitalization in New York, Steadman and colleagues (1984) concluded that
their combined findings from six states yielded little evidence that care for individuals with mental illness shifted to state prisons from the hospital. Only 5.7% of patients admitted in 1968, and 8.8% in 1978, reported a history of imprisonment. To explain the discrepancy, the authors suggested, as opposed to Penrose’s thesis that prisons would function to reinstitutionalize ex-patients, local jails might be a more plausible culprit. Steadman and colleagues stated:

The 3,493 jails in the U.S. that average 157,000 inmates each day are complex, fast-turnaround institutions. They are gate-keeping facilities. Such frontline institutions would be expected to bear the brunt of the initial impact of a large-scale social change such as mental patient deinstitutionalization. (1984, p. 489)

In summary, these articles reveal evidence of increased prevalence of the arrest of individuals with mental illness necessary for the criminalization hypothesis, but contradictions and methodological flaws fail to provide strong evidence for the criminalization hypothesis on these findings alone.

Another method used to investigate the validity of the criminalization hypothesis is to examine evidence of mental illness within correctional systems (Teplin, 1983). Bonovitz and Guy (1978) conducted a study of referrals to a 60-bed psychiatric unit of a Philadelphia prison, more closely resembling a jail in description, in the year before and after Pennsylvania implemented more restrictive civil commitment procedures. Based on the criterion of dangerousness, Pennsylvania’s Mental Health Procedures Act prohibited commitment of individuals who act bizarre or disorderly, but who were otherwise not an immediate danger to self or others. The study was limited to a correctional
facility in a major metropolitan area, timing was ideal, and the authors were careful to control for staff changes and monitor differences in inmate demographic characteristics that might create confounds. The three groups studied consisted of one control group before implementation of the act, and two subsequent groups at the 5th through 6th months, and the 13th though 14th months after implementation.

Without access to inmates' previous hospitalization records, Bonovitz and Guy (1978) reported three findings in support of the criminalization hypothesis. First, referrals to the psychiatric unit increased greatly in the 5th through 15th month after implementation of the mental health act, each month averaging 70% more referrals than each respective month before implementation. The prevalence of schizophrenia between referred groups remained consistent (74% to 80%), but larger percentages of detainees were referred to the psychiatric unit within their first week of admission, increasing from 37% to 52% over time. Additionally, unlike the first two groups, the last group more often had a history of placement on the psychiatric unit during previous incarcerations. Although incarceration is stressful, and could create decompensation in vulnerable individuals, this contention alone could not explain the sustained increase in referrals. During the research period, there were neither major staff changes nor significant changes in inmate demographics to explain such a result. The evidence suggests both an influx of individuals who appeared more ill on
admission, and an increase in decompensation in the community, leading to increased care provided within the correctional setting.

Second, Bonovitz and Guy’s (1978) examination of crimes and offense histories between the three groups revealed qualitative differences. Whereas referred inmates with a violent history decreased from 74%, to 47%, to 33%, individuals arrested for minor crimes (e.g. trespassing, disorderly conduct, or terrorist threats) increased inversely from 9%, to 18%, to 33%, while arrest history moderately decreased among the three groups. Therefore, in addition to greater numbers of psychiatrically unstable inmates arriving at the jail, findings imply that these inmates had fewer arrests, were less violent, were arrested for nuisance offenses, more so than before the implementation of restrictive civil commitment statutes.

Third, in contrast to the other groups, there were 13 individuals in the third group whose family initiated arrest, all of whom were deemed psychotic, and immediately referred to the psychiatric unit on admission (Bonovitz & Guy, 1978). These findings suggest support for the criminalization hypothesis, without making the sampling error of judging mental illness by hospitalization history alone. A lack of psychiatric records, however, complicates the conclusion that the criminalization hypothesis was responsible for this occurrence.

A final method to explore the validity of the criminalization hypothesis, suggested by Teplin (1983), is to examine evidence of mental illness at arrest, including police decision making. Bonovitz and Bonovitz (1981), like Bonovitz and
Guy (1978), studied the phenomenon surrounding the 1976 Mental Health Procedures Act in Pennsylvania. They examined the number of mental health related incidents that came to attention of law enforcement officials between 1975, the year preceding the restrictive commitment procedures, and the following years through 1979. The research pool consisted of a large suburb containing a population of more than 100,000, with mental health services including a mental health center just outside of the township, a private psychiatric unit within a hospital seeing only voluntary patients, and a state hospital in the bordering county seeing indigent individuals without insurance and those involuntarily committed.

Bonovitz and Bonovitz (1981) discovered a 228% increase in mental illness related incidents between 1975 and 1979, while the number of felonies increased 6% and the number of disorderly conduct cases increased 82%. Due to changes in classification and recording of disorderly conduct cases resulting in a misleading 700% increase during 1975, the 82% increase more realistically measured change in this category between 1976 through 1979. Although these statistics suggest support for the criminalization hypothesis, there are clear shortcomings.

Unlike previously mentioned studies, Bonovitz and Bonovitz (1981) mindfully excluded incidents involving mental retardation, senility, or substance abuse from those classified as mental health related incidents, but failed to provide an operational definition for mental illness related incidents. One of the
authors accompanied police for 100 hours to observe crisis response, but it is assumed the primary determination of what constituted a mental illness related incident lay within the hands of responding officers. Such an assertion could have underestimated the increased prevalence of mentally disordered individuals that came to the attention of law enforcement officials due to their limited training in diagnostic assessment.

Conversely, Bonovitz and Bonovitz (1981) cited officers’ opinions that results were due first to increased difficulty in obtaining commitment, coupled with shorter hospitalizations, and second, as one officer stated, “We know more about mental cases—used to be we didn’t even recognize it half the time. Since we started going to seminars it has made a big difference” (p. 974). The authors’ failure to cite how many officers received mental health training, and when they received it, could precipitate a dramatic reduction in Type II errors possibly confounding their conclusions if training occurred during the study. Though the study did not support the criminalization hypothesis, as police only arrested 13 mentally ill out of 100 arrestable infractions, their conclusions are debatable based on police training. It raises questions whether training might invoke empathy, influencing the decision to arrest, or whether police in other jurisdictions, without training, would be more likely to arrest. The study also excluded a comparable base rate of arrest for individuals without mental illness.

Teplin (1984) conducted a similar study with better methodological controls whereby graduate level clinical psychology students observed police for
2,200 hours over 14 months in two busy urban precincts of a large metropolitan area with over 1,000,000 people. Methodology established conservative standards for classifying mental illness to err on the side of making false negative errors by excluding behavior related to sociopathy and unusual or bizarre behavior of individuals without mental illness. To determine whether individuals with mental illness experienced arrest more often than the general population, traffic offenses and public service incidents with minimal chance of arrest were excluded, and only encounters where evidence sufficient for arrest was present, in addition to presence of a suspect, were included. These exclusions left a sample of 884 encounters with 506 suspects, 30 of whom were deemed mentally ill.

Teplin (1984) reported that of the 30 mentally disordered suspects, police arrested 14, or 47% of them, as opposed to 28% of 476 suspects without mental illness, leaving a nearly 20% disparity. She speciously argued that when arrests were split among six offense categories, individuals with mental illness were arrested at a higher rate. Half the categories had an \( n \) of 1, and another an \( n \) of 3, allowing misleading claims of a 100% arrest rate of individuals with mental illness in these categories using statistical slight of hand. Within the category of violations of public order, however, police arrested 7 of 15 (47%) of those with mental illness, as opposed to 21% of the individuals without mental illness, more reasonably suggesting those with mental illness were arrested for
lower level offenses. Unfortunately, Teplin did not apply a statistical analysis of power to individual findings allowing for more insightful interpretation.

To determine if an officer’s conclusion of mental illness played a role in the decision to arrest, Teplin (1984) examined the congruence between officer versus researcher findings of mental illness. Although she found 97% agreement between officers and researchers, officers recognized mental illness in only 15 of 30 mentally ill individuals encountered, leading her to conclude officers more often miss psychiatric symptoms due to Type II Error. She determined little difference, however, in the likelihood of arrest between those correctly identified as mentally ill (40%), versus those incorrectly not identified as mentally ill (53%). Whereas lack of mental illness training could influence arrest, numerous mitigating factors proffered by researchers of the era implicated officer judgment and systemic realities contributing to the criminalization hypothesis (Abramson, 1972; Teplin, 1984; Teplin, 1991; Whitmer, 1980). These arguments made firm and seemingly reasonable appeals to logic, though they were oftentimes anecdotal and suggested as de facto truth, without citing empirical support for their claims.

For instance, given the increased prevalence of individuals with mental illness in society, some without adequate treatment, the increased probability of decompensation with societal rejection of subsequent odd or bizarre behavior is a reasonable postulation. In such instances, law enforcement officials, for all practical purposes, bear sole responsibility to ameliorate the situation (Whitmer,
Whitmer stated the responding officer is rarely willing to diagnose “someone who has just committed a crime. He has neither the temperament nor the inclination to function as a mental health outreach worker for the population of forfeited patients, but this has become his new role” (1980, p. 72). Teplin (1984) contended that untrained officers might view the abrasive presentation of belligerence and oppositionality that can accompany mental illness as disrespectful, and therefore respond more punitively with arrest. Even if mental illness was apparent, systemic changes created by deinstitutionalization appeared to increase chances of incarceration. These included increased freedom to refuse treatment, more restrictive civil commitment statutes requiring a criterion of dangerousness while allowing hospitals to refuse patients too dangerous, and limited availability of facilities that treated comorbid conditions.

Abramson (1972) argued that the ability of those with mental illness to refuse treatment, coupled with stringent commitment criteria, created a situation for law enforcement where arrest and incarceration became more efficient for securing involuntary detention than seeking hospitalization. Civil commitment statutes that required imminent risk of dangerousness to self or others created a situation where hospitals denied individuals deemed too dangerous, leaving incarceration as the final option (Teplin, 1984). Teplin described the situation as ironic because “the major criterion for emergency detention or commitment in most States involves dangerousness. Thus, precisely the symptomatology required for emergency psychiatric detention might render the person
acceptable by some hospitals. The only available disposition may be arrest” (1991, p. 152). She also indicated that the paucity of programs treating comorbid conditions created further difficulty in securing treatment for offenders with mental illness. The tendency for the dually diagnosed mentally ill and chemically dependent or mentally retarded to disrupt the milieu of a ward often led to denial of treatment and subsequent incarceration.

If one accepts these non-empirical, albeit reasonably logical claims proffered by Abramson (1972), Teplin (1984), and Whitmer (1980), officer judgment easily becomes enmeshed with institutional realities, as revealed through a basic decision tree. Upon deciding for arrest, an officer must go through a decision process. Is the individual mentally ill or not? If not, jail, if so, and the hospital would serve the offender’s needs better, does the person fit commitment criteria for admission? If not, then arrest and incarceration is the choice. If so, do they refuse treatment, but exhibit behavior warranting containment (e.g. arrest and jail)? If they do not refuse treatment, do they suffer from comorbid conditions inhibiting hospitalization? If so, jail, if not, do they meet commitment criteria, but exhibit volatility inhibiting their admission, therefore leaving arrest and incarceration as the only option? Changes in commitment statutes, clearly effective in limiting what many perceived as a heavy-handed policy of institutionalization, disrupted institutional homeostasis (Abramson, 1972; Bassuk & Gerson, 1978; Estroff, 1981; Gilligan, 2001; Klerman, 1977; Scull, 1981; Whitmer, 1980). The dramatic shift in policy
successfully stymied institutionalization at the expense of leaving no other recourse but jail for those who were ill but did not meet commitment criteria, those who refused treatment, those dually diagnosed, or those too dangerous (Abramson, 1972; Teplin, 1984; Teplin, 1991). This is congruent with the assertions made by Abramson (1972); arrest becomes the path of least resistance when individuals with mental illness attract the attention of law enforcement.

The subsequent effects of more individuals with mental illness living in society, societal discomfort with active psychiatric symptoms, and reduced hospitalization length drove these non-empirical postulations for the increased incarceration of individuals with mental illness. Because of a confluence of forces during deinstitutionalization, Briar stated:

> When traditional pathways of care are blocked, the local jail becomes the recycling station for some deinstitutionalized persons. Like the old asylums, the jail increasingly functions as the one place in town where troubled persons can be deposited by law enforcement officers and not be turned away. As a result, the jail is, perhaps, our most enduring asylum. (1983, p. 388)

Many researchers supported the conclusion that despite the best intentions of the zeitgeist in the middle 20th century, jails merely took over the institutional role that hospitals once fulfilled, due to the jail’s inherent inability to deny anyone (Abramson, 1972; Bonovitz & Bonovitz, 1981; Estroff, 1981; Gilligan, 2001; Klerman, 1977; Scull, 1981; Teplin, 1983; Teplin, 1984; Teplin, 1991; Whitmer, 1980).
The Phenomenon of the Mentally Ill Inmate

Psychiatric beds decreased from 559,000 in 1955 (Quanbeck, Frye, & Altshuler, 2003), to 248,500 in 1973 (Taube, 1975), to 54,000 in 2000 (NRI, 2004). Correctional populations expanded from 504,000 in 1980 to 2,136,000 in 2004, while jail populations exclusively increased from 184,000 to 714,000 (BJS, 2005). In the middle 1980s, researchers began to focus less on the relationship between deinstitutionalization and the criminalization hypothesis, and redirected attention to the phenomenon of increasing numbers of mentally ill individuals in jails and prisons. Despite the inverse relationship between psychiatric beds and the correctional population, in addition to an undeniable population of mental illness within correctional facilities, one cannot definitively endorse either the criminalization hypothesis or Penrose’s theory. Such a conclusion naïvely excludes the possibility of improved screening, diagnosis, or other confounding factors. Regardless of causation, it is first necessary to establish evidence of mental illness within correctional systems before attempting to opine any relationship between mental illness and incarceration.

Despite decades of mixed evidence for the criminalization hypothesis, concerns of increased processing of individuals with mental illness through the criminal justice system, and evidence from smaller studies of a growing presence of mental illness within correctional systems, no national statistics on the prevalence of mental illness within correctional systems existed until 1999. Paula Ditton, of the Bureau of Justice Statistics, a branch of the United States
Department of Justice, conducted this seminal study. She concluded that approximately 283,800 mentally ill were incarcerated within the country’s jails and prisons; by her calculations, offenders with mental illness made up 7.4% of federal prison inmates, 16.2% of state prison inmates, and 16.3% of jail inmates (BJS, 1999). In 2006, James and Glaze, of the Bureau of Justice Statistics, published national statistics on mental health problems of incarcerated individuals. They concluded that approximately 1,255,700, more than half of the nation’s jail and prison inmates, suffer from mental health problems; by their calculations, 45% of federal prison inmates, 56% of state prison inmates, and 64% of jail inmates suffer from mental health problems (BJS, 2006). Statistical disparities stem from imperfect methodology in both studies, leaving the true prevalence of offenders with mental illness lying somewhere in between. To clarify the phenomenon examined in each study, it helps to investigate their operationally defined aspects of mental illness.

Ditton (BJS, 1999) classified inmates as offenders with mental illness if they reported staying overnight in a mental hospital or reported a mental or emotional condition. James and Glaze (BJS, 2006) determined mental health problems by presence of recent history (e.g. in the previous year, a mental health professional told them they suffered from a mental disorder, they were hospitalized overnight, took psychiatric medications, or received therapy) or a self-report of mental health symptoms in the past year. Both studies demonstrated two methodological flaws. First, both created false positives of
individuals without mental illness who abused drugs. Ditton did so by including individuals who spent a night in a psychiatric hospital due to substance use that presented as psychiatric disorder, prominently seen in abusers of methamphetamine and PCP. James and Glaze did so by inadvertently including substance use as the sole reason for reported mental health symptoms, in addition to including false positives hospitalized for a night. Second, both created false negatives of individuals who, knowingly or unknowingly, denied legitimate mental illness. Ditton created greater error by excluding those suffering from untreated mental illness, based on her operational definition. This important distinction is discussed later as untreated individuals, lacking evidence of treatment history, are not correctly classified as offenders with mental illness. Therefore, Ditton underestimated the prevalence of offenders with mental illness by excluding false negatives. James and Glaze overestimated prevalence by classifying anyone reporting even one symptom of depression or mania as an inmate with a mental health problem, regardless of severity or duration. Their measure did not determine if symptoms were severe enough to warrant diagnosis, were present before incarceration, or if the stress of incarceration induced the symptoms.

Despite flaws in these prominent studies exemplifying the issue of mental illness in correctional systems, they set a foundation for further research by establishing a range into more accurate estimations of mental illness. James and Glaze (BJS, 2006) allowed for a more precise estimation based on their
breakdown of the symptoms inmates reported relating to depression, mania, and psychosis. Whereas their inclusion of even one symptom explains the high prevalence of inmates with mental health problems in their study, closer examination suggests a more meaningful, yet guarded interpretation. Inmates with five or more depressive symptoms, or three to four symptoms of mania, may more likely suffer from a DSM-IV diagnosis of major depression or bipolar disorder, based on a congruent number of essential criterion needed for diagnosis. Considering this, up to 16% of federal inmates, 25% of state prison inmates, and 30% of jail inmates may suffer from major depression, and up to 23% of federal inmates, 31% of state prison inmates, and 40% of jail inmates may suffer from a bipolar disorder. Due to the serious nature of delusions or hallucinations, the presence of either suggested up to 10% of federal inmates, 15% of state prison inmates, and 24% of jail inmates might suffer from a psychotic disorder. It is important to consider that the occurrence of symptoms elicited by the very experience of incarceration itself may have increased false positives in this estimation of mental illness. Similarly, the sensory depravation of solitary confinement could easily precipitate a psychotic episode, even in inmates without mental illness, creating inflated estimations of mental illness, though such discussion is outside this paper’s scope. Methodological concerns clearly remain in the research by James and Glaze (BJS, 2006), including: failure to measure severity or duration of symptoms, inclusion of symptoms created from medical issues, incarceration, bereavement, or chemical use, failure to exclude
those malingering, failure to include those falsely denying symptoms, and the exclusion of inmates physically or mentally unable to complete the survey, or who were in mental hospitals. Despite these flaws, it is the best and most current estimation into the breadth of the prevalence of mental illness within correctional systems nationally.

Given foundational evidence that individuals with mental illness occupy a sizeable portion of correctional systems, one must explore the relationship between mental illness and incarceration to determine the validity of the criminalization hypothesis. Examining the role of jails, and particularly arrest data, appears most promising based on multiple factors. First, Teplin (1983; 1984) suggested that these are prime areas of interest when examining police handling of individuals with mental illness after deinstitutionalization. Second, Steadman and colleagues (1984) suggested jails are gate-keeping institutions with quick turnarounds, likely to see the greatest influx of former patients due to deinstitutionalization. Third, jails house a greater percentage of mentally ill inmates than do state or federal prisons (BJS, 1999; BJS, 2006).

Axelson and Wahl (1992) studied psychotic and non-psychotic misdemeanants admitted to a jail outside Washington D.C. over the course of 11 weeks. The psychotic misdemeanor group included 25 inmates referred for forensic evaluation by referral sources and who met DSM-III criteria for psychosis, and the non-referred misdemeanor control group included 25 inmates not referred for forensic evaluation. Sixty-four percent of the psychotic
misdemeanant group was charged with the most trivial, non-violent misdemeanors of disturbing the peace \((n = 1)\), disorderly conduct \((n = 5)\), and trespassing \((n = 10)\), compared to 16% for non-referred misdemeanants, charged with disorderly conduct \((n = 1)\) and trespassing \((n = 3)\). Although the psychotic misdemeanant group received charges for the most trivial nuisance offenses at a rate four times greater than the non-referred misdemeanant group, they experienced an average of 27 days confinement, compared to 4 days for the non-misdemeanant group, a disparity nearly seven times greater.

Teplin (1990; 1994) similarly published two separate epidemiologic papers based on a sample of 728 male detainees interviewed during intake at the Cook County Department of Corrections in Chicago, Illinois. Teplin (1990) reported that the prevalence of major depression, mania, and schizophrenia exists at a prevalence of 3.5 times greater within the jail than in the general population (6.4% versus 1.8%). She also reported that jail samples do not include those arrested and diverted to the hospital; therefore, they underestimate the degree by which mentally ill are processed through the criminal justice system. Teplin (1994) reported that inmates with severe mental illness were jailed most often for non-violent crimes. Of inmates with a current diagnosis of schizophrenia or manic episode, 15% committed a violent felony, 46% a non-violent felony, 4% a violent misdemeanor, and 36% a non-violent misdemeanor. Of those with a current diagnosis of major depression, 19% committed a violent felony, 46% a
non-violent felony, 15% a violent misdemeanor, and 19% a non-violent misdemeanor.

These findings (Axelson & Wahl, 1992; Teplin, 1990; Teplin, 1994) suggest that individuals with severe mental illness are more often incarcerated for nuisance or non-violent crimes, and appear within jails at a greater frequency than individuals without mental illness. However, support for the criminalization hypothesis is still far from unequivocal. Axelson and Wahl (1992) excluded the 20% of psychotic inmates with felony offenses, and failed to describe whether the misdemeanors of psychotic or non-psychotic inmates were violent or non-violent in nature. All three studies additionally excluded mention of comorbid conditions with chemical dependency or Axis II antisocial proclivities, creating the possibility of confounds.

Teplin (1990; 1994) was one of the few researchers to gather a pure random sample, with a large enough sample size to capture a valid measure of psychosis, a variable with a small base rate. Although the higher prevalence of severe mental illness in jail is necessary to support the criminalization hypothesis, the finding itself does not necessarily validate the conclusion. Teplin (1994) reported that the majority of offenders with mental illness were convicted of non-violent offenses in congruence with the criminalization hypothesis. Unlike Axelson and Wahl (1992), however, Teplin found no statistically significant contrast in the proportion of individuals with and without mental illness convicted of non-violent offenses. She also presented no raw data on specific infractions of
the law prohibiting readers from drawing their own conclusions, did not clearly indicate the prevalence of comorbid chemical dependency, and failed to mention Axis II comorbid conditions, the latter two of which could greatly influence criminality. Finally, it is not possible to conclude from Teplin’s findings whether criminality is attributable to untreated symptoms, or whether these individuals happened to be of sound mind at the time of the offense, supporting culpable criminality. Although these studies provided otherwise reasonable evidence, one must consider these limitations.

Comprehensive studies similar to Teplin (1984), attempting to provide difficult to determine findings on officer judgment at time of arrest, are virtually non-existent. Whereas she had a researcher accompany police to determine the presence of mental illness for an individual facing arrest, McFarland and colleagues (1989) took a different approach. They surveyed 260 families with relatives primarily diagnosed with schizophrenia (68%) or bipolar disorder (22%), who averaged four state hospitalizations. Approximately 83% were male, 72% were never married, 63% were unemployed, 76% lived on less than $5,000 a year, and 44% lived alone.

At the time of the survey, 4% of mentally ill family members were currently under arrest, 52% experienced arrest, though only 19% were convicted, and 45% experienced jail, but only 4% were actually imprisoned (McFarland et al., 1989). This suggested that offenders with mental illness were more likely arrested for nuisance, or other lower level offenses for two reasons.
First, jail rates were ten times that of imprisonment, suggesting shorter sentences for lesser crimes. Second, of the half previously arrested, only one fifth were convicted, suggesting insufficient evidence to continue incarceration, or arrest for the sake of inappropriate, though not necessarily illegal behavior.

Family members attributed 2.5 of the average 3.3 arrests to active mental illness and 83% of family members with mental illness were in psychiatric crisis during the most recent arrest, of which 40% were hospitalized following arrest (McFarland et al, 1989). Of the 83%, family members attempted and failed commitment in 46% of cases, though 34% of those were hospitalized after arrest. In essence, 40% exhibiting serious symptoms were hospitalized following arrest and the remaining 60% were jailed. One third of the 46% in psychiatric crisis who were denied hospitalization before arrest were eventually hospitalized, meaning two thirds in crisis were jailed after not meeting commitment criteria. Although this suggests a strong relationship between acute psychiatric symptoms with criminal justice involvement, and the significant role played by restrictive civil commitment standards, the authors instead focused on characteristics of the sample leading to arrest, rather than systemic contributions. They determined 13% of the sample had a comorbid alcohol or drug abuse diagnosis, and one third of the 74% prescribed psychiatric medications were medication non-compliant, making these the two marked arrest predictors.

Findings of McFarland and colleagues (1989) perhaps suggest that in a previous era with less restrictive civil commitment standards, these individuals
would have experienced greater supervision, both increasing treatment compliance and inhibiting substance use, thereby limiting encounters with the police. Additionally, if family members felt psychiatric crisis preceded arrest for 83% of subjects, it implies that less restrictive commitment standards would negate arrest opportunities for most of these individuals whose family attempted to intervene, as they did 50% of the time. Such commitment standards might further inhibit arrest by proactively creating treatment opportunity before extensive decompensation occurs.

The 13% comorbidity with alcohol and substance abuse reported by McFarland and colleagues (1989) is peculiar, being grossly lower than other national estimations. The Journal of the American Medical Association published an article by Regier and colleagues (1990), who determined 47% of individuals with a lifetime diagnosis of schizophrenia or schizophreniform disorder, and 61% of individuals with a lifetime diagnosis of Bipolar I disorder, carried a substance abuse or dependence diagnosis at some point in their lifetime. Such a preponderance of comorbid conditions might logically lead one to believe mentally ill individuals more often experience arrest for drug possession or trafficking, but the research overwhelmingly suggests otherwise. Both national studies on the prevalence of mental illness in correctional systems (BJS, 1999; BJS, 2006) reported offenders with mental illness were consistently incarcerated less often for possession or trafficking than offenders without mental illness – up to 30% to 40% less often. This does not negate, however, the possibility of
substance use exacerbating symptoms or increasing violence, or the influence of psychosocial stressors associated with drug use or poverty, all of which could likely contribute to criminality.

The most relevant concern between the criminalization hypothesis and comorbid mental illness and chemical dependency is not whether self-medication leads to incarceration, but its association with the mad vs. bad argument: the mad being insane, or not criminally responsible at time of offense, and the bad having intact faculties, whether mentally ill or not. For example, comorbid schizophrenia and substance use exacerbates symptoms; this combination was found to have the third highest correlation with violence (behind the frequency of higher arrests and comorbid psychopathy) in the most comprehensive study of risk assessment (Swofford et al., 2000; Monahan et al., 2001). These two factors of exacerbated symptoms and increased violence should theoretically increase interactions with law enforcement. Having a mental illness and being under the influence of drugs, however, does not preclude the possibility that offenders with mental illness are either not exhibiting psychiatric symptoms, or significant symptoms, so as to impair capacity, control, or ability to appreciate wrongfulness, as dictated by prevailing legal standards of criminal responsibility (Milton et al., 1997). Rather, it is possible these are merely individuals engaging in criminal behavior, albeit individuals with mental illness, but whose criminality is disproportionately driven by forces other than any psychiatric symptoms they might be experiencing. If it is true that psychiatric crisis precedes the majority of
arrests, and chemical use is the greatest predictor of arrest, then McFarland and colleagues (1989) is a rare study empirically supporting the confluence between active mental illness and chemical use with subsequent legal involvement. The literature is otherwise remarkably silent.

McFarland and colleagues (1989) provided a robust snapshot of experience for these individuals, but their research comes not without the final criticism of selection bias from surveying families with mentally ill members. If families know enough about an ill member to respond to a lengthy survey, they may play a greater support role. Although mentally ill individuals with supportive families still experience arrest, perhaps familial support decreases life stressors, increases possibilities of earlier intervention, and increases encouragement for voluntary treatment among other benefits, all likely to inhibit greater and more prolonged decompensation. Individuals disillusioned with their family, who lose contact during social drift in decompensation, or who are homeless are less fortunate with regard to such protective factors.

**The Compounding Influence of Homelessness**

Given the nature of limited access to a continually fluctuating population, in an economic system more tolerant of economic disparity and poverty’s implications, the true prevalence of homelessness in the United States is difficult to measure. Surveys of populations receiving services at soup kitchens and shelters underestimate the number of homeless by excluding those denied
services based on limited resources. Selection bias also excludes those whose paranoia inhibits service use. The Urban Institute (2000) conducted an independent analysis of 1996 U.S. Census Bureau data and speculated the number of homeless on any given night range between 444,000 to 842,000.

Breakey and colleagues (1992) examined data collected from a random sample of 528 homeless residents of missions, shelters, and the city jail in Baltimore, Maryland, between 1985 and 1986. Although they focused on stigma and stereotypes surrounding homelessness, they reported a high prevalence of mental illness within their sample. Thirty-eight percent of their sample suffered from major mental illness (e.g. schizophrenia, bipolar, or major depression), 24% suffered from comorbid mental illness and substance use or dependence, 15% suffered from paranoid personality disorder, and 12% from schizoid personality disorder. Of those with major mental illness, 47% had never experienced psychiatric hospitalization, though 61% scored *fair-poor* and 33% scored *very poor* or *grossly impaired* on a DSM-III Axis V measure of social and occupational functioning. That nearly two fifths of the homeless suffered from major mental illness, of whom nearly half were never hospitalized, supports a relationship between mental illness and homelessness, and perhaps, an increased likelihood of arrest and incarceration. Sixty-three percent of the sample experienced arrest as an adult, though the authors presented no data on mental illness in relationship to this statistic.
Ditton (BJS, 1999), who conservatively estimated national prevalence of mental illness within federal prisons, state prisons, and jails, reported markedly higher levels of homelessness for offenders with mental illness than those without. In the year before arrest, this frequency was six times greater federally (18.6% vs. 3.2%), two times greater at state prisons (20.1% vs. 8.8%), and nearly two times greater in jails (30.3% vs. 17.3%). In the month before arrest, homelessness among offenders with mental illness was thirteen times greater federally (3.9% versus 0.3%), three times greater at state prisons (3.9% versus 1.2%), and two times greater in jails (6.9% vs. 2.9%). The highest rates of homelessness for offenders with mental illness within the past year (30%) and past month (7%) occurred in jails. Both Ditton (BJS, 1999) and James and Glaze (BJS, 2006) concluded jails carried the highest prevalence of individuals with mental illness or symptoms, 16.3% and 64% respectively. Homelessness among offenders with mental illness, twice that of those without, is arguably associated with numerous psychosocial stressors contributing to problems ranging from desperation in meeting basic needs, concerns for personal safety, exacerbation of psychiatric symptoms, and psychological decompensation.

In comparing Breakey and colleagues (1992) to Ditton (BJS, 1999), it is important to recall that Ditton created greater error by excluding the untreated mentally ill from her sample, based on her operational definition, thereby-underestimating the number of offenders with mental illness. Breakey and colleagues (1992) reported that nearly half the homeless mentally ill studied
were never hospitalized. Hospitalization was one criterion Ditton used to
determine mental illness. Breakey and colleagues (1992) unfortunately did not
report on Ditton’s other criterion of report of a mental or emotional condition.
Ditton still reported that offenders without mental illness in jail had rates of
homelessness (17.3% within the past year and 2.9% within the past month)
multiple times higher than federal or state prison offenders (BJS, 1999). If half
the homeless individuals with mental illness studied in Breakey and colleagues
(1992) were never hospitalized, it is unclear how many received psychological
assessment to determine mental illness. In essence, if the homeless went
unhospitalized, without psychological care, it raises the concern of who would
have given them the diagnostic label to report to a researcher in Ditton’s study,
thus fulfilling Ditton’s operational definition of mental illness. Such a quandary
would substantially increase the number of false negatives in Ditton’s analysis.

These questions depend heavily on chronicity of homelessness and
availability of psychological resources within the criminal justice system. Although
the former is unknown, Ditton (BJS, 1999) reported on the latter. Approximately
41% of offenders with mental illness in jail received either medications or
therapy, as compared to 61% in federal prisons and 60% in state prisons, an
overall difference of one third. Data on the limited likelihood of hospitalization for
the homeless mentally ill, the reduced likelihood of receiving mental health
treatment in jails, and a limited prospect of receiving psychological treatment
when homeless, raises questions of how much Ditton underestimated mental
illness, with accentuated concern on jails and their disproportionate homeless populations.

In a study on the criminal implications of combined mental illness and homelessness, Martell, Rosner, and Harmon (1995) examined 77 mentally ill homeless defendants and 107 mentally ill domiciled defendants who received psychiatric referrals by courts in New York City over 6 months. The researchers measured criminality to determine how much homeless individuals with mental illness were overrepresented in varying offenses. Homeless individuals with mental illness exhibited 35 times the criminality of their domiciled counterparts, engaged in violent crime at 40 times the frequency, and non-violent crime at 27 times the frequency of domiciled counterparts. The authors concluded, “homeless mentally ill defendants were grossly overrepresented among mentally disordered defendants in New York City’s criminal justice system” (Martell, Rosner, & Harmon, 1995, p. 599). The homeless and domiciled defendants exhibited no differences in criminal history or prevalence of substance abuse, suggesting the combination of mental illness and psychosocial stressors of homelessness precipitate both violent and non-violent crime.

To counteract the effect of non-mental health professionals making referrals, stringent criteria for determination of mental illness removed false positives from the sample (Martell, Rosner, & Harmon, 1995). However, because psychiatric symptoms were prominent enough to trigger referral, and malingers were excluded, one might attribute some role of active mental health symptoms
in the crime. This is not to shortsightedly conclude the homeless or domiciled individuals with mental illness were *mad* at the time of the offense, and allows for the *bad* argument, as determination of criminal responsibility is an artful process contingent upon legal statutes. The presence of psychiatric symptoms in this context would be necessary, however, if the criminalization hypothesis were valid.

Martell, Rosner, and Harmon (1995) correctly commented on the incongruence between their disproportionate findings of violent crime and the thesis proffered by the criminalization hypothesis, that individuals with mental illness would be processed through the criminal justice system for low-level crimes. Their findings, however, do not contradict the broader thesis and evidence that active psychiatric symptoms contributing to arrest, perhaps inhibited by timely hospitalization in an earlier era, are now reactively managed in the criminal justice system. The factor of homelessness notably appears to exacerbate frequency of misconduct in those with mental illness. As this pertains to the criminalization hypothesis, homeless living conditions for hundreds of thousands of individuals with mental illness was likely an unanticipated outcome of deinstitutionalization. Those supporting the criminalization hypothesis perhaps failed to consider destabilizing forces of homelessness on coping mechanisms of individuals with mental illness and its effect of exacerbating symptoms, increasing both the risk of violence and criminality. In this light, homeless
individuals with mental illness have fewer protective factors than domiciled counterparts, creating a precarious situation for an already disadvantaged group.

In an intensive naturalistic study, Belcher (1988) tracked a group of 33 individuals with a history of chronic mental illness and homelessness, following release from an acute care ward. The individuals were hospitalized an average of 12.5 times in the past 5 years and although prescribed psychotropic medications on discharge, they instead self-medicated with drugs and alcohol. They quickly became homeless after release, but were interviewed weekly to establish how the demands of mental illness and homelessness influenced their involvement with the criminal justice system. The author also maintained collateral contact with the staff of soup kitchens, shelters, community mental health staff, law enforcement officials, and social workers.

Over the course of six months, 64% were arrested, primarily due to bizarre or threatening behavior in public, as reported by collateral contacts; 75% of those were arrested for either assault, disorderly conduct, petty theft, or trespassing, serving an average of 7.9 days in jail (Belcher, 1988). Although a third of the sample continued to receive social security or welfare payments, they were unable to use these payments to buy personal necessities due to their decompensation. Belcher stated:

Barter gradually replaced the use of currency; as the respondents became more decompensated the ability to use currency to purchase tangible objects, such as consistent food, clothing, and shelter, became increasingly difficult and wandering the streets in search of basic survival became the norm for these individuals. (1988, p. 192)
He concluded the combination of mental illness, a non-structured environment, lack of participation in voluntary outpatient treatment, and medication non-compliance contributed to decompensation, leaving these individuals less able to care for themselves as they roamed the streets in an ill state until law enforcement intervened.

Left without adequate treatment and support, many individuals formerly institutionalized faded to society’s margins and languished; without family or significant social supports to help ensure basic needs and treatment as needed, social drift became reality for these individuals (Estroff, 1981; Gilligan, 2001; Klerman, 1977; Scull 1981; Whitmer, 1980). A lack of outreach programs inhibit early intervention, while substance use and significant life stressors further exacerbate psychiatric symptoms (Gilligan, 2001; Klerman, 1977; Regier, 1990; Whitmer, 1980). The outgrowths of inflamed symptoms and inability to meet one’s basic needs from the presence of extreme poverty, psychological decompensation, and limited avenues for treatment can potentiate criminality and/or increase interactions with law enforcement (Abramson, 1972; Belcher, 1988; Teplin, 1983; Teplin, 1984; Teplin 1991; Whitmer, 1980). Briar (1983) argued that when traditional treatment pathways are suppressed, jails take over the functions of hospitals due to their inability to turn anyone away, thus making them the most enduring asylum. This thesis holds greater relevance for homeless individuals with mental illness, who live a subsistence lifestyle at the fringe of society, ill, uncared for, without supports, frequently with chemical dependency
problems, and facing possible of victimization daily. Given their circumstances and lack of resources, incarceration yields their greatest chance of receiving treatment.
DISCUSSION AND CONCLUSIONS

Penrose (1939) argued that society would find a way to keep its undesirables out of sight, be it through the prisons or institutions. Abramson (1972) discussed fears that more restrictive commitment criteria and ability to refuse treatment that came with California’s LPS act, the Magna Carta for those with mental illness, could ironically have the opposite effect of increasing pressure on the criminal justice system to contain the social problem by making arrest and incarceration the path of least resistance. Whitmer (1980) speculated that the forfeited patient, unemployed, medication non-compliant, disinterested in treatment, without a significant social network, and gravely in need of services but unable to procure them, would become the marginalized chronically mentally ill societal outcast.

To stymie the burgeoning hospital population, the Joint Commission on Mental Illness and Health proffered guidelines that set the stage for the Community Mental Health Act, which sparked the substance of deinstitutionalization (Gilligan, 2001). Psychiatric beds decreased from approximately 559,000 in 1955 (Quanbeck, Frye, & Altshuler, 2003), to 248,500 in 1973 (Taube, 1975), to 54,000 in 2000 (NRI, 2004). Early research, heavy in theory, but lacking in empirical evidence, speculated that many individuals formerly institutionalized were being processed through the correctional system (Abramson, 1972; Whitmer, 1980). It became apparent that the Commission’s essential recommendations of increased funding and change in public perception
(Ewalt, 1961) never came to fruition (Bassuk & Gerson, 1978; Gilligan, 2001; Klerman, 1977; Steadman & Cocozza, 1978; Teplin, 1991). As time passed, analyses across comparable institutional populations and studies with greater methodological integrity began to draw more substantive connections between deinstitutionalization and the criminalization of individuals with mental illness (Bonovitz & Bonovitz, 1981; Bonovitz & Guy, 1978; Brill & Malzberg, 1962; Steadman, Cocozza, & Melick, 1978; Steadman et al., 1984; Teplin, 1983; Teplin, 1984). In the middle of the 1980’s, however, researchers redirected their focus to the phenomenon of increasing numbers of mentally ill individuals in jails and prisons. The literature has generally maintained this emphasis through today, moving away from associations with deinstitutionalization.

The literature reveals a tentative relationship between deinstitutionalization and the increased prevalence of individuals with mental illness within correctional systems, but this relationship is neither clearly firm nor linear. Difficulties in tracking such a process and flawed research methodology merely complicate findings. National studies estimating the prevalence of offenders with mental illness somewhere between 16% and 64% within jails alone exemplify this concern. Whether there is sufficient evidence to claim the criminalization hypothesis as the criminalization theory, however, may be a moot issue of semantics that actually detracts from the broader issue. When the nation is left not knowing the extent of the problem a half a century after the advent of deinstitutionalization, despite three decades of research suggesting concern, the
matter becomes one greater than that of attempting to nail down illusive evidence.

What comes into question is the fabric of cultural values in the United States. To say this nation has collectively failed to provide for a largely economically unproductive, and easily ignored population with expensive treatment needs, is a judgment statement. The relationship between deinstitutionalization and the increased prevalence of mental illness in correctional systems is not a cause and effect relationship. Rather, it resulted from a confluence of forces. The political zeitgeist and American consciousness have driven *tough on crime* attitudes, cuts in social programs, economic trade-offs leaving a strained mental health system, marked increases in homelessness, and the largest prison population in the world (Thomas, 1998; Walmsley, 2005). The consequences of the nation’s decisions, *good or bad, helpful or harmful*, are a matter of debate, but its decisions speak to its values.

As Dorothea Dix rallied for federal mental health reform in the middle 19th century, she lobbied through four presidential administrations, until a bill passed both houses of the legislature. President Pierce, steadfastly against federal funding of her initiative, vetoed the bill on the grounds of equanimity and the autonomy of individual states. He stated:

It is not exclusively worthy of benevolent regard. Whatever considerations dictate sympathy for this particular object apply in like manner, if not in the same degree, to idiocy, to physical disease, to extreme destitution. If Congress may and ought to provide for any one of these objects, it may and ought to provide for them all . . . . I can not find any authority in the Constitution for making the Federal Government the great almoner of
public charity throughout the United States. To do so would, in my judgment, be contrary to the letter and spirit of the Constitution and subversive of the whole theory upon which the Union of these States is founded. (Richardson, 1897, p. 249)

Where Dorothea Dix failed at the federal level, she succeeded at the state level. Yet, federal resistance persisted through the later half of the 20\textsuperscript{th} century as seen in the aforementioned exclusion in funding for Institutions for Mental Diseases (IMD), otherwise known as the IMD exclusion. Geller (2000) reported the federal government played a limited role in funding IMDs from 1965 through 1988. In 1989, however, IMDs were redefined as facilities with greater than 16-beds after the Supreme Court reiterated the intent of the IMD exclusion – that \textit{individual states} bore the responsibility to provide treatment for the long term care of those with chronic mental illness. The large cut in the federal funding provided further incentive to move the remaining chronically ill from state hospitals by restricting funds to facilities with 16-beds or less.

Thomas (1998) discussed a sociological perspective to cuts in social programs in the 1980s driven by a political atmosphere focused on law and order, fiscal conservatism, and a shift to neoconservative values. Cutting costs of the social safety net reduced what some felt was a bloated federal budget or undue federal influence on individual states. Shifting greater responsibilities to states and decreasing or eliminating federal support for some social programs was thought to create a more favorable business climate, giving American corporations an edge in recovering from the economic hardship and inflation of
the 1970s. These cuts contributed to a decline in the overall number of psychiatric beds in the United States while other changes occurred.

Thomas (1998) reported that the number of private psychiatric centers increased from 184 in 1980, to 450 in 1988, creating treatment opportunity for those with adequate medical insurance. Fewer public dollars were available for psychiatric treatment and civil commitment statutes were tightened, except for individuals with mental illness who posed a threat to others, congruent with prevalent tough on crime attitudes, and the doubling of correctional beds between 1980 and 1988 (Thomas, 1998; BJS, 2005). Thomas (1998) reported that cuts in the safety net and gentrification of the 1980s contributed to the displacement of many individuals with mental illness concentrated in inner cities. As affordable housing disappeared, they became homeless, left without resources to receive treatment in the private sector.

Wuerker (1997) reported on the implications of state mental health funding cuts on homelessness. She tracked the amount of time between a client’s initial entry into the Los Angeles County Department of Mental Health system, and follow up admission to a service (e.g. inpatient treatment, outpatient treatment, day treatment, psychiatric emergency room admission, or jail mental health service), with report of homeless status. Using archival data between 1973 and 1993, she found a highly significant correlation ($r = .66$) between the previous year’s funding with length of time before individuals became homeless. Time between initial admission, and utilization of a service
with homeless status, dropped from approximately 170 months to 140 months between 1974 and 1975, 120 months to 80 months between 1979 and 1980, 75 months to 25 months between 1982 and 1985, and 20 months to 10 months between 1988 and 1990. Funding cuts preceded each period – approximately 170 million to 120 million between 1973 and 1974, 150 million to 140 million between 1978 and 1979, 150 million to 115 million between 1981 and 1984, and 145 million to 140 million between 1987 and 1989. Correlation does not equate to causation; however, the mere leveling out, not increase of time before homelessness with previous year’s funding increases, and systematic decline in time before homelessness, are interesting and concerning observations.

Considering the theory proffered by Penrose, longstanding federal resistance to comprehensively fund treatment for individuals with severe mental illness, and erosions to social programs providing a safety net, the large prevalence of mentally ill individuals in the corrections system appears more of a natural consequence than accident. The emerging picture of mental health care over the past 150 years is one of general improvement over the long term, marked by intermittent stagnation and decline in the intermediary. These fluctuations seemingly coincide with the joust and parry of the conflicting national values of social responsibility and fiscal conservatism.

Systemic implications of policy decisions and cultural values are clearly delineated on a national level and within the literature, but the easily ignored practical implications extend to many local communities. Systemic problems have
real life consequences as indicated by a personal interview with a psychiatric nurse working on a forensic psychiatric unit in a St. Paul hospital. The unit treats only males, with a greater propensity for assaultive behavior, higher incidences of homelessness, and higher levels of substance use and incarceration. Hospital policy dictates patients are to receive an appointment for a medication check two weeks after discharge and another appointment at one month, to determine the necessity of a follow-up appointment with a psychiatrist, with subsequent placement on a waitlist for an appointment. However, the nurse emphatically stated that, at that time, the appointment at one month after discharge was averaging three months, “not for an appointment, but to get on the list to get an appointment. Then the appointment is set for months after that. So this patient may not get an appointment after discharge with the psychiatrist for six months or greater” (D. Bruschette, personal communication, February, 2006).

The nature of these systemic problems, as they pertain to the criminalization hypothesis, became more apparent as this nurse described a common occurrence with Ramsey County Jail inmates sent to one of the two sanctioned jail cells on her unit. She used an example of some inmates who received treatment, after being arrested for “beating up a bus.” She stated:

When people are ill at jail and come here, they are stabilized on meds and sent back to jail. On discharge from jail, they get no meds and no appointment, and call here for meds, but can’t get them because they aren’t being treated by this MD, so within two to three weeks they are psychotic and beating up the bus again and back in jail. (D. Bruschette, personal communication, February, 2006)
Such examples paint a picture of a broken system and the deleterious realities of significant policy changes over the decades. Comprehensive treatment resources within correctional systems have not fully compensated for limited treatment resources in the community, creating a further treatment gap for those inmates with mental illness released from jails.

The confluence of factors mentioned and the sum of their implications glaringly fail to take into account racial disparities within the correctional system within the United States. The Bureau of Justice Statistics (2003) reported the rate of African American males ever imprisoned in 2001 (17%), was twice as high as the number of Hispanic males ever imprisoned (8%), and six times higher than the number of Caucasian males imprisoned (3%). The disproportionate number of African American and Hispanic men incarcerated within the correctional system suggests minority populations with mental health problems are more apt to receive mental health treatment through the criminal justice system, rather than the mental health system, even more so than the general population. Such hypotheses remain little more than speculation; the literature is remarkably silent on the racial implications of deinstitutionalization, in addition to the propensity for individuals of different races to receive treatment within the criminal justice versus mental health system.

The literature appears largely colorblind regarding the issue of race in deinstitutionalization and as a factor in treatment disparity. One study suggested that, in congruence with other jail diversion programs, individuals diverted from
the criminal justice system through mental health courts “were more likely to be older, White and female than individuals being arrested . . . [the finding is] consistent enough to warrant further investigation” (Steadman et al., 2005, p. 224). Another study more clearly exemplified broader racial concerns by comparing racial differences in county referrals to either a state hospital or prison. Grekin, Jemelka, and Trupin did not support the overall criminalization hypothesis, but nonetheless concluded:

Mentally ill racial minority members are overrepresented in the prisons. Different counties use the criminal justice and mental health systems differently for removing mentally ill persons from the community. Race is a factor in these differences, and the differences cannot be explained by higher incarceration rates in the predominant minority population. (1994, p. 419)

Given striking racial disparities in correctional populations nationwide, it is curious that the literature has not largely taken interest in how racial disparity plays into the criminalization hypothesis. This largely unstudied issue demands the attention of future research.

Although the situation today is not as overtly bleak and tragic as that encountered by Dorothea Dix in the middle 19th century, there has always been a traditional swinging of the proverbial pendulum of treatment standards for mental illness. Humane treatment in asylums supplanted the neglect, abuse, and punishment of those with mental illness in an earlier era. Limited funding and ballooning populations contributed to the formation of warehouses and snake pits, giving asylums a pejorative association. The prevalence of individuals with mental illness within correctional systems is a complex issue researchers have
not fully come to grasp, leaving society to struggle with a solution fitting within its cultural values. Treating mental illness reactively within correctional systems may not be ideal, but it does not preclude such a possibility. As the system currently exists, other options seem scant.

If society decides that addressing the issue of significant portions of individuals with mental illness within correctional systems is a responsible decision in line with its cultural values, a good deal of further research would be necessary. More firm estimations on the extent of the problem would be of foremost importance to postulate funding and resources necessary to address the problem. Assessment upon intake would open the door for necessary treatment and segregation from general population inmates without mental illness. The effect would be three-fold. First, it would prevent manipulation or victimization by non-mentally individuals with antisocial tendencies. Second, it would create a therapeutic milieu during stabilization and recovery. Third, it would allow for greater consideration of psychiatric symptoms in determination of culpability during institutional rule infractions. This could limit the all too common and disproportionate placement of individuals with severe mental illness in solitary confinement, an experience more likely to exacerbate symptoms through the effects of sensory depravation (Grassian & Friedman, 1986; Hodgins & Cote, 1991; Roberts & Gebotya, 2001).

In jails, where stay is limited, other changes could promote further progress. Instituting commitment standards could mandate limited containment
necessary for stabilization and treatment. A bridge between correctional staff and case management could ensure a smooth transition between incarceration and outpatient settings, ranging from a group home to individual residence. This could help guarantee the inmate’s necessities were met, in addition to probationary stipulations of compliance with medication and outpatient treatment. Such intervention would theoretically stymie extensive decompensation and expedient return to jail, thus simultaneously providing both necessary treatment and savings from repeated arrest and incarceration. After implementation of such objectives, further research could clarify the nature of the problem for chronically ill individuals, or those with antisocial tendencies resistant to such a treatment process, thereby allowing modifications in levels of care.

No solution is without shortcomings. This solution is likely superior to the current predicament, if it fits within the nation’s cultural value system. The nation’s humanitarian values likely deem the current paucity of treatment unacceptably inhumane. Likewise, the repeated and costly incarceration of an unemployable and mentally ill population created by deinstitutionalization cannot help but create economic drag; at some level, this functions contrary to the more preeminent national values of industriousness and economic success. If the value of fiscal conservatism trumps all, however, then the criminalization hypothesis is a moot issue, leaving the nation to accept the consequences of current circumstances until some future shift in the zeitgeist.
After more than 50 years of deinstitutionalization and 30 years of research, society still lacks a clear understanding of the scope of the problem correctional systems face with a growing population of individuals with mental illness. Treatment for offenders with mental illness is limited to 60% of that population in state and federal prisons and 41% in jails (BJS, 1999). Options are limited for mental health care upon release. Without resolution, these factors create an otherwise untenable position. It leaves society to continue paying the economic and humanitarian costs of a marginalized group continuing in a cycle of release, decompensation, arrest, and incarceration.
REFERENCES


