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Keeping the Peace:
The Parameters of Police Discretion in Relation to the Mentally Disordered

by

Linda A. Teplin

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James K. Stewart
Director

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Introduction

The goal of this study was to examine some of the peacekeeping aspects of policing, with special attention devoted to understanding the nature of informal resolutions. Specifically, we have chosen to focus on police involvement with mentally-ill persons, and their handling of situations involving mentally-ill suspects.

The focus on police handling of the mentally-ill was based on two factors. First, the majority of situations resulting in the presence of the police do not involve the commission of major crimes, nor do they require a formal invocation of the law (arrest). Police (and observers of police) know that situations resulting in arrest comprise only a fraction of those incidents which come to their attention. Despite this fact, the majority of previous studies of policing have focused almost exclusively on the decision to arrest or not to arrest as the pivotal decision. Thus, it is particularly unfortunate that the research literature, to date, provides precious little information about the way in which police spend the preponderance of their time and effort. This study was designed to correct this omission in the existing literature.

The second reason underlying our focus on police and the mentally-ill is based on the changing role of the police officer in relation to the mentally-ill. The police are increasingly called upon to act in the role of streetcorner psychiatrist. This is a result of a number of changes in the configuration of the mental health service delivery system. For example, deinstitutionalization has resulted in a marked increase in the number of mentally-ill persons residing in the community. Unfortunately, since there is a paucity of outpatient mental health programs, the mentally-ill may act in such a manner such that they commit legal transgressions, albeit minor, which result in the presence of the police. Similarly, changes in the mental health codes have tightened commitment criteria, thus making it more difficult to commit persons who, in another era, would have been hospitalized for their disorder. As a result of these complex factors, the mentally-ill have become a more visible presence within the community. Thus, police become involved with the mentally-ill, not out of choice, but rather as a result of their being summoned by citizens, and requested to "do something." Although police officers are not trained mental health professionals, they are nevertheless required to resolve the situation so as to satisfy the citizenry.

Clearly, the police have become a major mental health resource. Despite their responsibility for handling the deinstitutionalized mentally-ill, there has been only one major study in this area, conducted by Egon Bittner (1967). While this investigation is an excellent examination of the myriad of ways in which police maintain the mentally-ill within the community, the data were collected prior to deinstitutionalization. What is needed is a contemporary examination of this problem. In sum, the changes wrought upon the community by modifications in public policy (deinstitutionalization) requires that we reexamine the role of police in managing the mentally-ill. This study and final report are an important first step in adding needed information concerning what has become a very major peacekeeping police function --handling and maintaining mentally-disordered persons within the community.

This final report is divided into three sections. Chapter I examines in depth each of the three possible alternatives the police may use to resolve situations involving mentally-disordered persons: arrest, hospitalization, and "informal dispositions." This chapter demonstrates that the relationship between a citizen's mental disorder and the police officer's decision regarding the resolution of that situation is neither simple nor direct. Rather, the type of disposition chosen is a result of a complex number of socio-

psychological exigencies, all of which interact to shape the final disposition of the encounter.

Chapter II focuses on the arrest decision. While arrest is an infrequently-used disposition, it is nevertheless most instructive to examine situations in which it is invoked. A particularly important aspect of this chapter is the finding that the mentally-ill have a significantly higher probability of arrest than apparently "normal" suspects. Thus, although arrest is not a particularly prevalent disposition, it is nevertheless used as a way to manage those mentally-ill citizens for whom no alternative disposition is available. This chapter explores some of the reasons underlying the police officer's apparent propensity to disproportionately arrest mentally-disordered suspects.

Chapter III turns from the police officer to the citizen. Rather than asking what the police do, this chapter focuses on that behavior which precipitates police involvement. This is particularly important data, since the chapter contains information that debunks the popular myth that the mentally-ill comprise a particularly dangerous and criminal element. This information is particularly critical to training police what they may expect when encountering mentally-disordered citizens. We conclude that police encounters with mentally-disordered persons are more likely to take the form of a situation in which the mentally-ill are in danger of harming themselves, rather than criminal activity per se.

It is hoped that this report will fulfill a rather glaring omission in the research literature. In particular, these data confirm that the police officer's role is only remotely related to that popularized by the (rather entertaining, albeit inaccurate) television program, "Hill Street Blues." This study shows that policing does not consist of merely arresting "bad guys," but is an incredibly complicated activity, made even more difficult by the requirement that the police, in effect, maintain deinstitutionalized persons within the community. In short, the goal of this report is to inform police researchers, administrators, and ultimately, the officers themselves, about the myriad of situations which police must find ways to resolve. Truly, police have become the streetcorner psychiatrists; moreover, their "office" never closes.

Managing Disorder: Police Handling of the Mentally Ill

Police have long been recognized as a primary mental health resource within the community. They play a major role in referring persons for psychological treatment, particularly within the lower socioeconomic strata (Warren, 1977; Sheridan & Teplin, 1981; Gilboy & Schmidt, 1971; Bittner, 1967; Munoz et al., 1969; Rock et al., 1968; Liberman, 1969; Hollingshead and Redlich, 1958). The realization that police serve as a mental health resource has led to a number of studies of police handling of the mentally-ill (cf. Bittner, 1967); Matthews, 1970; Rock et al., 1968). However, while these investigations have made important contributions to the research literature, they predate significant public policy reforms (e.g., deinstitutionalization) which have complicated the relationship between police and the mentally-ill. Given the potential effects of these changes in public policy, what is needed is an examination of police practices within the current socio-political milieu. Drawing on data from an observational study of 1396 police-citizen encounters, this chapter will examine police involvement with mentally-disordered citizens, with particular emphasis on describing the decision-making rules underlying the three major resolutions: (1) hospitalization, (2) arrest, and (3) "informal" disposition.

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Background:

Police involvement with the mentally-ill may be traced to common law and is grounded within two legal principles: (1) the police power function, i.e., to protect the safety and welfare of the public; and (2) parens patriae, which involves protection for the disabled citizen (Fox and Erickson, 1976; Shah, 1975). Most mental health codes specify the parameters of police involvement with the mentally-ill, and instruct police to initiate a psychiatric emergency apprehension whenever the person is either "dangerous to self or others" or, "because of his illness is unable to provide for his basic physical needs so as to guard himself from serious harm." (cf. Ill. Revised Statutes, 1981; California Welfare and Institutional Code; N.Y. Mental Hygiene Law)

Despite the legitimacy of police authority afforded by most mental health codes, the disposition of mentally-ill persons is by its very nature a complex social process. While the law provides the legal structure and legitimacy of the police officer's power to intervene, it does not (and indeed cannot) dictate the police officer's particular response in any given situation (Bittner, 1967). The police, unlike other professionals (e.g., physicians), do not have a body of technical knowledge which they may use as formulae in the performance of their role (Rumbaut & Bittner, 1979). As with all law enforcement decisions, the police must exercise discretion in choosing the most "appropriate" disposition (Goldstein, 1979; Manning, 1977; Wilson, 1968), and thus develop an informal operative code to "handle the situation." In mental health cases, the situation is further exacerbated by the inherently nebulous definition of "mental disorder." There is a large grey area which, depending on cultural values and administrative practice, might be labeled as being either criminal or psychiatric (Stone, 1975). In short, dispositional decisions vis a vis the mentally-ill are an inherently problematic social judgment.

Although a number of studies have investigated or commented on the interaction between the police and the mentally ill (Cumming, Cumming and Edell, 1965; Liberman, 1969; Matthews, 1970; Sims and Symonds, 1975; Teplin, et al., 1980; Fox and Erickson, 1976), there has been relatively little research examining the officer's decision-making process. The most significant work in the area was conducted by Bittner (1967). Bittner found that police were hesitant to make psychiatric referrals, and they made such referrals reluctantly. In the police officer's view, hospitalization was initiated only when the case became or had the potential of becoming a serious police problem. The elements which made a case a "serious" police matter were indications that, if a referral were not made, external trouble would proliferate, e.g., danger to life, physical health, property, to order and/or public places. Thus, Bittner found that police required that there be indications of external risk accompanied by signs of serious psychological disorder (e.g., suicide, violent acts, public nuisances) in order to justify a psychiatric referral. The mental hospital was not the police officer's first choice; the decision to initiate a hospitalization was a residual resource, the utilization of which was determined by the absence of other non-official alternatives. Other investigators have confirmed police reluctance to initiate an emergency apprehension, and have found that their underlying sentiment is that transporting the mentally-ill is an inappropriate task for a police officer (cf. Rock et al., 1968; Matthews, 1970; Schag, 1977).

Structural constraints further reduce the likelihood of police initiating a hospitalization. Rock et al. (1968) found that the more procedural steps there were between the street and the hospital, the less likely the emergency procedure would be employed by the police. Similarly, Matthews (1970) noted that the police officer must calculate how much time alternative courses of action would consume as compared to hospitalization.

In light of the pivotal role the police play vis a vis the mentally-ill, it is somewhat surprising that there have been relatively few recent investigations of this relationship. With the exception of two rather small-scale studies (cf. Schag, 1977; Urmer, 1973), there has been no major study of this issue since Bittner's (1967) seminal work. This omission is all the more crucial given that there have been several major public policy modifications instituted since Bittner collected his data. First, deinstitutionalization has resulted in numbers of persons receiving outpatient treatment within the community who would have formerly been hospitalized. Second, the legal context regarding patient rights has resulted in specific restrictions regarding psychiatric treatment. Finally, fiscal reductions in mental health programs have resulted in an increasing number of mentally-ill persons who, because of a lack of available programs and/or a paucity of individual financial resources, are denied treatment (Kiesler et al., 1983). These factors have had the cumulative effect of increasing the numbers of mentally-ill persons residing within the community (Kiesler, 1982b; N.I.M.H., unpublished) and also, presumably, increasing the frequency of police-citizen contact. At the same time, reductions in mental health funding have reduced the available number of inpatient beds in public hospitals (N.I.M.H., unpublished), as well as the breadth of treatment alternatives (Kiesler, 1982b). In short, changes in public policy have increased the burden of the mentally-ill on law-enforcement officials. At the same time, the more stringent mental health codes and the diminished treatment options reduce the available referral options.

In view of these countervailing policies, police are likely to have adapted their informal operative code to the current socio-cultural milieu. This chapter will set forth the basic decision-rules central to the three major alternatives available to police: (1) hospitalization; (2) arrest; and (3) informal dispositions. In so doing, it will be demonstrated that the

disposition of a mentally-disordered citizen is based less on the degree of apparent symptomatology than on a complex array of contextual and situational variables.

Method

In order to avoid the aforementioned limitations of retrospective data and/or official statistics, a naturalistic but quantifiable data set was required. It was decided to conduct a large scale observational study of everyday police activity in order to observe firsthand how police officers handle mentally-disordered persons in general, as well as to compare the incidence of arrest for mentally-disordered persons versus those who are not mentally disordered. To this end, police officers in a large northern city (Standard Metropolitan Area over 1,000,000) were observed in their everyday interactions with citizens for 2200 hours over a fourteen-month period during 1980-81; 283 randomly-selected officers were included. Observers included the author as well as five clinical psychology graduate students (three male, two female). Observations were conducted during all hours of the day; evenings and weekends were oversampled in order to obtain a maximum of data within a minimum amount of time. Data were collected in two busy urban police precincts, which included residents ranging from the lowest socio-economic level to the very wealthy. These two precincts are fairly typical of this particular city, and are fairly generalizable to any large northern urban area. All types of police-citizen interactions were observed, irrespective of any mental health component. This procedure was necessary in order to be able to obtain data on situations unrelated to mental health to use as baseline comparisons.

Although a standardized mode of assessment to test for the presence of mental disorder would have been preferable, the naturalistic setting of the research obviously precluded making in-depth streetcorner psychological assessments aimed at discovering hidden pathology. In view of the limitations imposed by the naturalistic setting, the presence of mental disorder was ascertained by the fieldworker via a symptom checklist which listed the major characteristics of severe mental illness, e.g., confusion/disorientation, withdrawal/unresponsivity, paranoia, inappropriate or bizarre speech and/or behavior, and self-destructive behaviors. Thus, criminal behavior per se was not defined as being indicative of mental disorder, despite the fact that it is included in the D.S.M. III (APA, 1980) as a symptom of sociopathy (DSM III 301.70). Rather, the focus was on identifying those persons who were visibly suffering from the more severe forms of mental illness (e.g., schizophrenia, major affective disorders, etc.).

A person was defined as being mentally-disordered if he or she possessed at least one of these traits and was also given a global dummy rating of "mentally-disordered" by the fieldworker. Both the presence of such traits and the global rating were necessary in order to avoid categorizing persons as being mentally-ill when they were merely exhibiting bizarre or unusual behavior. The environmental context as well as a number of extra-psychiatric cues were taken into account by the fieldworkers when making these judgments. An example will clarify the need for this procedure. A "streetperson" who is found by police to be shouting and running down the street naked on a cold night in January would have been coded as being mentally-disordered. However, similar behaviors exhibited on a warm June evening by a group of drunken college students were recognized as being bizarre, albeit not indicative of mental disorder. It should be stressed that the definition of mental disorder was made conservatively in order to err in the direction of making fale negative (Type II) rather than false positive (Type I) errors. All fieldworkers were students from a graduate clinical psychology Ph.D. program, and had received extensive training in conventional assessment techniques as part

of their graduate program. Nevertheless, in order to ensure that this measure accurately discriminated between persons who did and did not exhibit signs of serious mental disorder, a validity study was undertaken. Using a sample of 61 randomly-selected jail detainees, the results of the measure used in the present investigation were compared to those generated via a standard psychological instrument, the N.I.M.H. Diagnostic Interview Schedule (Robins, Helzer, Croughan, Williams, & Spitzer, 1981). It was found that the two measures were correlated quite highly; Fisher's Exact Test, p. < .001; Kendall's Tau-b = .739; Yule's Q = .977. There was 93.4% agreement between the two measures as to the presence/-absence of severe mental disorder (psychosis).

In order to minimize evaluation apprehension on the part of the police officers, neither tape recording devices nor extensive note-taking was permitted during the observations. The apparent lack of an obvious formal data-collection procedure appeared to enhance cooperation between police officers and observers. In order to facilitate recollection of the data for subsequent transcription, fieldworkers were allowed to make a list of all the police-citizen encounters that took place during the observational period. A sample list might read: "(1) 9:20 p.m., shoplifting at Peoples Drug Store; (2) 10:15 p.m., disturbance in schoolyard, Byrne Elementary School;" etc. This list was subsequently used by the fieldworker to facilitate data transcription. Data recording was conducted in two ways, quantitatively and qualitatively.

1. Quantitative Data. The objective characteristics of the encounter were coded according to an instrument specifically developed for this purpose, the "Incident Coding Form." This instrument was designed to record the concrete behaviors and descriptive categories central to the police officer's handling of all police-citizen encounters. It was extensively pilot-tested prior to the data collection, and tests of inter-rater reliability exceeded 97% for the coded information. An Incident Coding Form was completed for every encounter between a police officer and a citizen which involved at least three verbal exchanges. In order to maximize inter-observer reliability, all fieldworkers were given three months of special training using both videotapes and field situations. In addition, reliability was subsequently monitored via periodic spot checks.

2. Qualitative Data. Each fieldworker was given a dictaphone for home use so that a narrative of the shift could be reconstructed after the observation period. These qualitative data were recorded according to a specified format which included general shift information, impressionistic data concerning the fieldworker's observations of the officer, and, most important, a complete narrative of all police-citizen encounters. This last data component detailed the reasoning underlying police officers' discretionary judgments in relation to their handling of the situations. Approximately 1800 pages of qualitative information were recorded.

Overall, 1,382 police-citizen encounters involving 2,555 citizens were observed and coded. Excluding traffic-stops, the data base includes 1072 police-citizen encounters involving 2122 citizens. However, only a portion of this data base is relevant to the present research question and will be presented. Of the 2122 citizens observed in the 1072 police-citizen encounters, 85 persons involved in 79 encounters were defined by the field-worker to be mentally-disordered. This chapter will present an analysis of these 85 apparently mentally-disordered citizens. Given the nature of the

research question,the bulk of the analysis is confined to the qualitative data, of which there are two types: (1) data from the 79 observed police-citizen encounters involving the 85 mentally-disordered citizens; and, (2) anecdotes communicated to the fieldworker by the officer concerning the officer's prior experiences in handling mentally-disordered persons.

Findings

Table 1 illustrates the relative frequency of the three major dispositional categories: (1) hospitalization; (2) arrest; and, (3) "informal". As Table 1 illustrates, hospitalization is an exceedingly infrequent event (less than 0.5%). Arrest, although occurring more frequently among apparently mentally-disordered persons than among non-mentally ill persons (see also Chapter II) is also a relatively rare disposition. Table 1 shows that police most frequently resolve a situation informally (71.8% for persons exhibiting signs of serious mental disorder and 93.5% for non-mentally-ill persons). Given the potentially disruptive nature of many of the symptoms of mental disorder, it is most interesting that police so rarely resort to a formal disposition. This analysis will present some of the underlying factors characterizing each of the three major dispositions. Drawing information from the qualitative data, the following sections will demonstrate that the dispositional decision is a complex construction of reality, related only peripherally to the degree of psychiatric symptomatology.

1. Hospitalization.

The apparent disinclination by police to initiate an emergency hospitalization is strikingly similar to the findings of Bittner (1967). However, while the results of the two studies are substantially similar, the raison d'etre for the infrequent utilization of the hospital was based on a number of structural characteristics peculiar to the current post-deinstitutionalization milieu. First, police initiation of hospitalization is limited by the reduced number of psychiatric placements available to them. While state hospitals once were the primary treatment facility, they have been replaced by community-based mental health centers. Unfortunately, these mental health centers (many housed within private hospitals) have very strict criteria for admission.

The qualitative data indicate that virtually every police officer was aware of the rather stringent requirements for admission into the local psychiatric hospital: the individual must be seriously ill, e.g., be actively delusional or suicidal. Police knew that persons who were mentally retarded, alcoholics or defined by hospital staff to be "dangerous" were persona non grata at the hospital. Similarly, persons with criminal charges pending, no matter how minor, were deemed unacceptable. It was common knowledge among officers that if the citizen did not fit the above-mentioned criteria, another disposition was needed. The following vignette illustrates an encounter that fulfills the above mentioned criteria for hospitalization:

> We were on the scene in less than a minute. The citizen in question was a black male, about 45 years old, who was standing on the sidewalk with his arms outstretched, spinning around in circles. The sergeant, making reference to the officer's background, said the man was a training helicopter pilot. The officer and the sergeant got the man to stop spinning. They attempted to question him, but the man was completely out of it. He gave no indication that he understood what was going on. He didn't talk at all during the encounter. The officer called for a wagon to take the man to (the hospital). (Shift 86, Encounter 3)

The following was a case in which the mentally-disordered person was too public in their deviance to be ignored by police. Hospitali-

zation was initiated because the citizen fulfilled the hospital's criteria that the patient be seriously delusional.

> At 22:00 a radio call came on saying there was a white female, age 28, who was taking off her clothes in front of the (___) Building. As we arrived, there were several other officers on the scene. A white female, age 28, was dressed in dirty clothes and was very dissheveled. She was repeatedly pulling up her T-shirt, exposing herself and making obscene gestures at the crowd that had gathered. Several officers helped her into the wagon. She kept saying, "Fuck the mayor." She said she had walked all the way from (the suburbs) to make some statements to the mayor. When the officers put her in the wagon, she continued yelling things out the back.... There was no evidence of alcohol or drugs, so it looked like a straight psychiatric case. (Shift 171, Encounter 2)

Suicide attempts are taken quite seriously by the police, and are readily admitted by the hospital, as indicated by the following anecdote:

> Three months ago, Officer I was working the midnight shift. It was about 2:30 a.m. He was driving and had another officer with him. They .....happened to notice a man standing on a corner, wearing a sweatshirt, parka, and slacks. He was about thirty years old, white. As they drove by, they noticed him wave. They said it was the kind of reaction where he probably didn't really need the police until he saw them, and decided to stop them. They .....came back, pulled up, with the passenger-side officer rolling down his window and asking what he wanted. The man responded that he wanted to go to the (psychiatric) hospital. They asked him why. Before anyone could do anything, he pulled out a knife and plunged it into his chest. (Shift 38)

Despite the importance of police in aiding the mentally-ill, "handling mentals" was not regarded as a good pinch, and was largely unrewarded by the Department. This, coupled with the scarcity of placements and the strict criteria for admission, tended to inhibit psychiatric referrals. Moreover, the current philosophy of community-based treatment apparently discourages police from using the hospital as a resource. Police perceive rapid deinstitutionalization of "their mentals" to be both a personal slight on their judgment, as well as an indication of the hospital's unwillingness to "do something." All of these factors serve to inhibit mental health referrals, and enhance the likelihood of other types of dispositions.

2. Arrest.

Arrest was not a particularly frequent disposition; only 16.5% of the 85 mentally-disordered persons were arrested. Nevertheless, the arrest-rate for persons exhibiting signs of serious mental disorder was significantly greater than that of non-mentally-ill citizens for similar types of incidents (See Chapter II). Apparently, there are a number of characteristics common to situations involving mentally-disordered persons which appear to increase the probability of arrest. The requirements of policing are to handle situations such that the officer is not required to return to the scene (Bittner, 1967). As a consequence, arrest was often the only disposition available to the officer in situations where persons were not sufficiently disturbed to be accepted by the hospital, but were too public in their deviance to be ignored. The qualitative data from the present investigation indicate that it was common practice for police to obtain a signed complaint in situations where the person was thought by police to require psychiatric hospitalization. The logic under-

lying this procedure was to ensure the ready availability of an alternative disposition (arrest) in the event that the hospital found the individual unacceptable for admission. The police officers' apparent ingenuity was clearly born out of necessity since, as previously mentioned, the hospitals had very specific criteria for admission. The following vignette illustrates a situation in which the person is apparently mentally-disordered, but is thought to be insufficiently ill to be accepted by the hospital.

> The officer indicated that this man had been on the street calling women names, calling them whores, and shouting at black people, calling them "niggers" and chasing them. The officer said he thought the guy was crazy, "you know, paranoid." .....A woman had signed a complaint and asked that he be arrested because he was bothering her....The man sounded like a paranoid schizophrenic...both from my observation of him and his response to questions the officer put to him in the station. He was very vague about himself and who he was, and felt that people were out to get him. He couldn't understand why he was in the police station. When he was taken to his cell, he began shouting to be let out, and kept shouting the rest of the time I was there. The officer said the man denied having had any psychiatric treatment or being under psychiatric care. In this situation, he was charged with disorderly conduct. The officer said that there wasn't enough to take him into the mental health center, because his behavior wasn't that severe for the hospital to accept him." (Shift 119)

Similarly, in situations in which the person is defined to be "too dangerous" by the hospital, arrest is the only disposition available to the officer:

> A young man was banging on his mother's door with a meat cleaver. ..He was threatening to kill someone else and was trying to get into his mother's home for a gun. She wouldn't let him in, and had called the police to get rid of him and/or to calm him down. When the police got there, Officer II decided the man needed to be hospitalized as he was dangerous to himself and others. So they called for a wagon to take the man to the mental health facility. ...but (they) also wanted a complaint signed by the mother for disorderly in case (the hospital wouldn't take him). It turned out (the hospital) would indeed not take the man so he ended up being locked up for disorderly. (Shift 180)

The irony in this type of situation is that it is precisely the requirements for emergency psychiatric detention set forth in most mental health codes ("dangerous to self and others") which render citizens undesirable by the hospitals, and result in their arrest.

Persons who exhibit symptoms which cross the boundaries of the care-taking systems meet a similar fate. As previously mentioned, mental health programs found persons with alcohol problems to be disruptive to the patient milieu, and often would not accept them for treatment. Conversely, detoxification facilities felt they were not equipped to deal with persons exhibiting signs of mental disorder, and would turn away persons with such "mixed" symptomatology. The following is a rather typical situation in which the jail was the last stop of several in an attempt to find a placement for a person plagued with a variety of problems.

> At 8:00 p.m., we heard a siren and saw that an ambulance was stopping in back of a parked bus. We got out of our car at the same time the ambulance personnel got out. They ran inside the bus and brought out a large burly black

man. The officers greeted him with great warmth and friendliness; they exclaimed, "Charlie, what are you doing?" Charlie greeted them with equal warmth and friendliness. Evidently, Charlie was the neighborhood character, and was drunk. The bus driver, not realizing Charlie was drunk, was afraid he was ill and had called for an ambulance. The paramedics, seeing that Charlie was only drunk, left him in our charge. (The officers) asked Charlie if he wanted to go to detox and Charlie said, "sure." They asked if he were sure detox would take him and he said, "Sure man; of course." ...We got him in the car and went to detox. There the people took one look at Charlie and would not accept him. Evidently, he was potentially violent and disruptive and bothered the other people at detox, as well as the personnel. The officers asked if they would sign a complaint. They said yes. Charlie realized that he was going to the lock-up and was very unhappy about it, laid down on a bed and took off his shoes. The officers tried to cajole him, telling him that they were going to take him to see "Jones," evidently a friend of his at the station. Charlie said, "I'm no fool, you suckers," and wouldn't put his shoes on. After about 10 minutes, we transported him to the station. Evidently, he had been there so often that they already had a sheet on him, so it was very quick to get him into a cell. The Officer explained to me that Charlie was a problem because he wasn't crazy enough to go to the mental hospital. The people at (the mental hospital) wouldn't accept him because he was potentially violent and often drunk. The detox people didn't want him, even though he was an alchoholic, because he was potentially violent, and bothered their other patients with his crazy ways. So that left the jail. They would put him in lock-up overnight; he would go to court in the morning, and then would be released. In the meantime, they would get him off the street. Charlie was booked for disorderly conduct. The detox facility was the complainant, although he had done nothing disorderly. (Shift 81, Encounter 3)

The tendency of persons with "mixed" symptomotology to be arrested appears to be a function of the overall configuration of the health delivery system. Our public health system is comprised of a rather fragmented assortment of components. Although a complex array of services is available, each sub-system designs its programs to fit a specific need; the majority of programs are designed as if clients were created as "pure types." In this way the narrow parameters of each of the various sub-systems result in a number of persons who are unacceptable for treatment in any health care facility. As illustrated in the above vignette, police would often make the rounds of the various service agencies -- from halfway house to hospital to "detox" -- before resorting to arresting the citizen.

As Bittner (1967) found, the "seriousness" of the incident also determined the disposition. However, unlike Bittner's study, the definition of "seriousness" in the present investigation was not always correlated with the severity of the offense. A number of socio-psychological and sociostructural contingencies determined whether or not the "seriousness" criterion would be invoked. For example, situations in which the citizen was disrespectful of the police officer were nearly always thought to be "serious":

> Call began at 09:45 when we received a call to investigate a disturbance at the subway station on _____ Avenue. When we arrived on the scene, we were met by a female newspaper dealer, who said there had been a woman there yelling and screaming and trying to

take some of the newspapers. She said that she had called the police, but the woman who had caused the problem had left....As we were walking out, however, this woman came back into the subway station.....the newspaper woman pointed to her and said that she was the one who was causing the problem. The officer turned to (the suspect) and asked her what the problem was. She jumped on the police officer and started hitting him with closed fists, and she was really landing some blows. He was taken by surprise but, after a brief struggle, he was able to pin her hands behind her and lead her out of the subway station to where the car was parked. During this time, she began screaming at him that he was an agent of the devil and that she was a messenger from God; that she would see to it that he was punished by God for having her arrested. Nevertheless, he put some handcuffs on her and called for the paddy wagon. The paddy wagon came, and he put her in the wagon to be taken down to the station and arrested on a disorderly conduct charge. ...The woman seemed to be clearly mentally-disordered. ...It seemed clear to the officer that since she was disturbing the peace, she was going to be arrested for that. (Shift 291, Encounter 2)

Similarly, situations which were public, offended "decent" people, and had a willing complainant were defined by police to be serious:

> We arrived...and were met by an elderly woman who said there was a man sleeping in a car behind the apartment building. She said that the night before this man had been acting real crazy and had thrown rocks at the building. She pointed out the car...and we saw the suspect sleeping in the back seat of a rather old Dodge. The suspect presented a very bizarre sight. According to his driver's license, he had until recently shoulder-length hair. But, in what looked like a very bad attempt at self-hair cutting, all his hair had been cut off. Most of his hair was off, but there were ridges of hair all over his head and actual gouges in the scalp. There were also slash marks up and down his wrists, extending up to his elbows. The citizen looked disoriented, was very filthy, but looked physically fit, perhaps a body builder at one time. He was quite acquiescent. Since other officers had the assignment, they put cuffs on him and told him they were going to take him in for damage to property and, probably for disorderly conduct. (Shift 284, Encounter 1).

In sum, arrest was used as a disposition in three types of situations: (1) when hospitalization would have been preferable, but the potential patient was thought to be either unacceptable by the hospital, or whose symptomatology was such that they fell into the cracks between the various caretaking systems; (2) in encounters which were characterized by their "publicness" and visibility, which, at the same time, exceeded the tolerance for deviant behavior within the community; and (3) in situations in which the police felt that there was a high probability that the person would continue to "cause a problem" were something not done. In such encounters, police would resort to arrest as a way of removing the problem person from the scene.

In general, police made a formal disposition (either hospitalization or arrest) in circumstances where, if unchecked, the situation would escalate and require further assistance from the police. If the circumstances of the case indicated that a formal disposition was required, the officer decided whether the person could fulfill the criteria for hospitalization, or if the criminal justice system

should be invoked. The large grey area between behavior that is "mentally-disordered" and that which is merely disorderly allows a great deal of discretion in choosing the ultimate disposition. The degree of psychiatric symptomatology is only one of the determining factors.

3. Informal Dispositions:

As has been found in previous studies (Bittner, 1967; Schag, 1977) informal dispositions were the predominant type of resolution; police handled 71.8% of all mentally-disordered persons informally. They are the preferred means of disposition, requiring neither paperwork nor unwanted "downtime" (i.e., hours off the street). There are three major categories of mentally-disordered persons who are likely to be handled via informal means: (a) neighborhood characters, (b) "troublesome persons," and (c) quiet, unobtrusive "mentals."

(a) Neighborhood Characters. Neighborhood characters are persons who reside within the community and whose idiosyncracies are widely renowned among police working within the precinct. Virtually any officer can tell you about "Crazy Harry," "Ziggie," "Batman," the "Lady in Red," and "Mailbox Molly." These are all neighborhood characters who are defined by police as "mentals," but who are never hospitalized because they are "known quantities." Police have certain expectations regarding the parameters of the neighborhood character's behavior. As a consequence, a greater degree of deviance is tolerated from them. More important, the officers' familiarity with the citizen's particular symptomology enables them to readily "cool them out," further facilitating an informal disposition. The following anecdote related by an officer is a rather common encounter of this type:

> There's a lady in the area who claims she has neighbors who are beaming rays up into her apartment. Usually, he said, he handles the situation by telling her, 'we'll go downstairs and tell the people downstairs to stop beaming the rays," and she's happy. The officer seemed quite happy about this method of handling the problem. He could do something for the lady and, even though it's not quite the same as the kind of assistance he might give another type of situation, he could allay the lady's fears by just talking to her." (Shift 220)

Similarly, the following anecdote describes a situation in which a neighborhood character wishes to report a crime to the police, and is greatly comforted by the officer's apparent concern.

> Recently, a man in his mid-thirties ...called the police to inform them that he was being monitored by another man. He said the man had planted a microdot in his apartment and kept track of his every action. He claimed the man who was monitoring him was able to jam his CB radio and call the man obscenities over the radio. He asked the officers to listen. He said, "See what that man's calling me?" The officers just heard garbled voices. The man said he'd also called the FBI and wanted to file a formal report with the police. The Officer said he went along with the man, letting him think the officers would take such a report, but he didn't do anything with the information The man seemed appreciative of their efforts, and they told him to let them know if he got any more information on the threatening man. The man was clearly disturbed but, as he was not dangerous to himself or others, he was not taken to (the mental hospital). The police just humored him. (Shift 213)

In contrast, evidence of mental disorder exhibited by an individual unknown to the officer tends to result in formal dispositions,

as the following encounter indicates. In this case, no attempt was made to reason with the person, and an emergency apprehension was initiated:

> The officer related a story to me about a man who had opened all the windows in his apartment and gone out on the roof because he felt the Martians were going to come. He wanted to disconnect all the household appliances and let out the bad air so they wouldn't destroy him. The officer felt that this was someone who needed psychiatric help, and he was brought to a mental health facility. (Shift 036)

(b) Troublemakers. If a mentally-disordered citizen has been labelled as a "troublemaker," the probability of a formal disposition -- either hospital or arrest -- is extremely unlikely. Such people are thought to be too difficult to handle to warrant intervention. The following story is typical of such a case.

> I think Harry is paranoid. Whenever the police go near him for any reason, even if it had nothing to do with him, he would get very upset and begin calling downtown, causing all kinds of flak in the department. So they leave him completely alone, even though they feel he is a certified cashew nut. (Shift 036)

A similar situation was a person rejected by the mental hospital who, "whenever she came into the station, she caused an absolute disruption. She would take off her clothes, run around the station nude, and urinate on the sergeant's desk. They felt it was such a hassle to have her in the station, and in lock-up that they simply stopped arresting her." (Shift 036)

Thus, being defined as a "troublemaker" allows the individual to act in ways which would otherwise tend to result in either arrest or hospitalization. Police feel that, although intervention may be periodically warranted in such cases, such persons are not worth the trouble.

(c) Unobtrusive "Mentals." Persons whose symptoms of mental disorder are relatively unobtrusive are likely to be handled informally. Such persons offend neither the populace nor the police with vocal manifestations of their illness. Their symptoms are not seen as being serious enough to warrant hospitalization. Moreover, quiet "mentals" are seen as being more disordered than disorderly, and are unlikely to provoke an arrest. The following encounter typifies a proactive interaction with an apparently mentally-disordered, albeit unoffensive person:

> "As the Citizen waved to us, the officer identified her as a "crazy lady," stating he had seen her before, although he had never had any direct contact with her.....She was about 65, white, dressed bizarrely, hair in great disarray. She was wearing many layers of clothing, none of which were in great shape.....(The citizen) spoke in a hyperactive, excited way, and had a wild, fearful look. She told us this involved story about having friends who used to live (here) and ...now were afraid to come back. She hoped the officer could do something to get these people to return, as she was now without friends and feeling destitute. The officer asked if they had moved. She said no, that they went out of town and had left their car on the street, and the car had picked up a lot of parking tickets. Her friends somehow learned about these tickets and were afraid to come back to (Midwest City) as they thought something terrible would happen to them because they had all these tickets. The Citizen's story didn't make any sense, but, in response to the Citizen's distress, (the officer) became quite placating, sympthetic and reassuring.

> Rather than arguing that there was no reason for her friends' fear, he told her what to tell her friends to do, i.e., that they could go downtown and probably have some of the tickets dropped, since they had been away. This didn't work too well. ....The officer then gave up after the citizen wasn't placated, ending by saying, "Okay, it'll be alright dear. We have to go now." (Shift 278, Encounter 5)

In the above situation, the officer attempted to placate the citizen, and allay her fears. She was neither sufficiently disordered to warrant a mental health referral, nor disruptive such that an arrest was in order. She simply needed someone to talk to, and the officer served as a mental health worker.

Conclusion

Police are a major mental health resource, perhaps even more so in recent years as a result of deinstitutionalization and a host of other public policy reforms. In order to handle situations involving mentally-disordered persons, police have developed a complex informal normative code. This chapter has demonstrated that the decision to arrest, hospitalize, or handle a mentally-disordered person via informal means is based less on the degree of symptomatology per se, than on the exigencies and constraints pertinent to each situation. The police do not rely excessively on conventional mental health resources; arrests, too, are relatively rare. Informal dispositions are (as in situations involving non-mentally-disordered persons) the disposition of choice. Through the police officers' prior experiences with the the neighborhood characters, they know precisely how to respond in order soothe the mentally-disordered person without medication or hospitalization. Their acquired wisdom enables police to act as a "streetcorner psychiatrist" when called to the scene. In this way, they help to maintain many mentally-disordered persons within the community, and make deinstitutionalization a more viable public policy. Police departments must be made aware of their pivotal role as a mental health resource, and train their officers accordingly. In this way, police handling of the mentally-ill will be a legitimate function, instead of an unwanted burden placed on the criminal justice system.

Table 1

Police Disposition of Apparently Mentally-Disordered and Non-Mentally-Disordered Citizens*

Disposition	Non-Mentally Disordered	Mentally Disordered	Total
Hospitalized for Mental Disorder	0 (0/0%)	10 (11.8%)	10 (0.5%)
Arrested	133 (6.5%)	14 (16.5%)	147 (6.9%
"Informal" (Other)	1904 (93.5%)	61 (71.8%)	1965 (92.6%)
Total	2037	85	2122

* Includes all citizens, regardless of their role in the encounter.

Excludes traffic incidents.

Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill

A number of mental health professionals have commented on what has been termed the "criminalization of mentally-disordered behavior" (Abramson, 1972), and have speculated that persons who had heretofore been treated within the mental health system are increasingly being shunted into the criminal justice system (Rachlin, Pam & Milton, 1975; Swank & Winer, 1976; Whitmer, 1980; Morgan, 1981; Lamb & Grant, 1982). Perhaps in response to this outcry, a number of professional organizations have either set up task forces (The American Bar Association) or convened symposia (the National Coalition for Jail Reform) in order to develop innovative public policy procedures and/or alternatives to handle mentally-ill persons within the criminal justice system.

Given the consternation expressed by mental health professionals and public policy makers about this state of affairs, it is somewhat surprising to find that the criminalization hypothesis, to date, has been based largely on intuition and unsystematic observation, and has not yet been subject to adequate empirical test (Teplin, 1983). Clearly, before public policy changes are implemented, further confirmation that the mentally ill are being criminalized is required. This chapter provides data which is a first step in that direction. Based on quantified data from an observational study of 1382 police-citizen encounters, this investigation compares the arrest rate of persons exhibiting signs of severe mental disorder with that of apparently non-mentally-ill persons. In so doing, this chapter provides preliminary data indicating some directions for public policy reformulation.

Teplin, Linda A. Criminalizing mental disorder: The comparative arrest rate of the mentally ill. American Psychologist, 39(7), 794-803, 1984. Reprinted by permission of the publisher and author.

Background: Changes in the Social Milieu Set the Stage for Criminalization

A number of changes in the socio-cultural milieu may have set the stage for the criminalization of mentally-ill persons. First, deinstitutionalization resulted in large numbers of persons being released into the community who formerly would have been given custodial care in a state or county facility. Evidence for this trend can be found in several sources. Long-term inpatient care has largely disappeared. According to the National Center for Health Statistics (Kiesler, 1982b), the mean length of stay for state and county hospitals has decreased from 421 days in 1969 to 189 days in 1978. In addition, both the numbers of inpatient beds and the average daily inpatient census in state and county hospitals have decreased by two-thirds between 1969 and 1980 (National Institute of Mental Health(NIMH), 1983). Although this trend has been balanced somewhat by an increase in the mental health services provided by community mental health centers (NIMH, 1983) and general hospitals (Kiesler et al., 1983), the net effect has been for the mentally ill to be an ever-increasing presence within the community.

Second, modifications in the legal code regarding patient rights have resulted in specific restrictions regarding psychiatric treatment. As a consequence, there are greater restrictions on both procedures (Addington v. Texas, 1979) and criteria (Lessard v. Schmidt, 1975) for commitment (Wexler, 1983). Moreover, the right of the mentally-ill person to live within the community without treatment has been confirmed (cf. O'Connor v. Donaldson, 1975; Rennie v. Klein, 1981; Rogers v. Okin, 1980). These changes have resulted in an unknown number of mentally-ill persons who now reside within the community, many of whom choose to function without the assistance of psychiatric treatment.

Third, when inflation is taken into account, federal support for mental health treatment has actually declined since 1975, resulting in a lack of available treatment programs for the deinstitutionalized person (NIMH, 1983; Kiesler et al., 1983). Thus, fiscal reductions in mental health programs have resulted in an increasing number of mentally-disordered individuals who are denied treatment because of a lack of available programs and/or a paucity of individual financial resources.

The cumulative effect of these changes is that the mentally-ill have increasingly become a more visible presence within the community. Unfortunately this trend has not been accompanied by a concomitant increase in the community's acceptance of mentally-disordered persons. Clearly, there is a limit to society's tolerance of the mentally ill, particularly given the stereotype of the mentally ill as "dangerous" (Shah, 1975; Fracchia et al., 1976; Steadman and Cocozza, 1978), as well as the bizarre and disruptive nature of many of the symptoms of mental illness. As a consequence, citizens often invoke the criminal justice system to handle situations involving the mentally ill, particularly in instances in which persons publicly exhibit the more frightening and disturbing signs of mental disorder (Bittner, 1967; see Chapter 1).

Unfortunately, although handling the mentally ill becomes the responsibility of law enforcement officials, their dispositional options are limited by several factors. First, initiating an emergency hospitalization, although explicitly permitted by most state mental health codes (cf. Ill. Revised Statutes, 1981; California Welfare and Institutional Code, 1980; NY Mental Hygiene Law, 1980), is often so fraught with bureaucratic impediments that such a referral is extremely difficult in practice (Matthews, 1970). Second, police action is further limited by the aforementioned more stringent legal criteria governing both commitment and treatment (see Chapter 1).

Finally, most psychiatric programs will not accept all types of patients. For example, persons thought to be "dangerous" (Bowden, 1978) or those with numerous previous hospitalizations (Kirk and Therrein, 1975) are among the most unwanted clients of mental health agencies. Clearly many persons may fall into the "cracks" of the system, e.g., those who are thought to be too "dangerous" to be accepted for treatment but not dangerous enough to be committed.

Given the many bureacratic and legal impediments to initiating mental health referrals, police might consider arrest to be a less cumbersome and more reliable way of removing the person from the community. Due to the lack of exclusionary criteria, the criminal justice system may have become the institution that can't say no. Persons rejected as inappropriate for the mental health system are readily accepted by the criminal justice system. As a result, the jails and prisons may have become the long-term repository for mentally-ill individuals who, in a previous era, would have been institutionalized within a psychiatric facility.

In sum, there are a number of structural factors indicative of criminalization. However, the empirical evidence vis-a-vis the criminalization hypothesis is problematic at best. A recent review of the research (Teplin, 1983) presented the rather diverse literature relevant to the criminalization hypothesis and delineated three major areas of research: (1) archival data, e.g., studies assessing the arrest rates of mentally-disordered persons, or comparing the relative populations of psychiatric institutions and jail or prison facilities; (2) studies of police handling of the mentally ill; and (3) surveys of the prevalence of mentally-disordered detainees in jails. Given the diversity of the research literature, one might hope that the findings would be illuminative of a general trend. Unfortunately the research is so fraught with methodological problems as to preclude any definitive conclusions regarding

the criminalization thesis (Teplin, 1983). Specifically, the previous research has three major limitations: (1) the type of data used; (2) the type of samples; and (3) the point in the criminal justice process at which the samples are drawn.

1. Type of Data: Previous investigators have largely relied on retrospective data and/or official statistics. There are at least two drawbacks inherent in this type of data. First, official statistics are notoriously inaccurate and unreliable, and may reflect more of a change in the recording of information than in actual reality. Second, the value of archival information is limited by the incomplete picture such data offer. Evidence confirming the limitations of archival and/or retrospective data abound in the research literature. For example, a number of investigators have indirectly investigated the criminalization issue by comparing the arrest rates of psychiatric patients with baseline arrest rates. With relatively few exceptions (Steadman, Vanderwyst, & Ribner, 1978), these studies have confirmed that former mental patients have higher arrest rates than the general population. Although such research represents an important first effort in this area, the results are of limited utility vis-a-vis the criminalization issue. Because the circumstances of the arrest are not known, the data pattern does not indicate which of two conclusions are warranted: (a) that mentally-ill persons are more prone to crime and, therefore, have a higher arrest rate; or (b) that, other things being equal, the characteristic of mental disorder enhances the probability of arrest in any given situation. Similarly, studies of police handling of mentally-disordered persons have largely relied on arrest reports or self-report retrospective data (Bonovitz and Bonovitz, 1981; Monahan and McDonough, 1980). Again, the value of such studies vis-a-vis the criminalization hypothesis is limited, both by the notorious inaccuracy of police reports as well as the questionable reality generated via retrospective data.

2. Type of Sample. The majority of researchers restricted their studies to samples of previously-hospitalized persons. Obviously, such research systematically excludes those mentally-ill persons who because of lack of sophistication, resources, or pure happenstance are not formally recognized as being disordered and requiring treatment. This sampling procedure is particularly problematic given that it is likely to be precisely such mentally-ill persons who, although never hospitalized, have the greatest chance of being processed through the criminal justice system. Labeling theorists suggest that the initial label that a person is given (i.e., "mental patient") substantially affects the ways in which that person's subsequent behavior is defined and interpreted (Becker, 1963; Rosenhan, 1973). It is possible that unlabeled persons (i.e., individuals who are mentally-disordered but have never been hospitalized) have a greater chance of being arrested for their publicly deviant acts than persons who have been labeled as mental patients via prior hospitalization. In short, research restricted to samples of previously-treated mental patients does not provide data necessary to test the criminalization hypothesis, and a less biased sampling strategy is required.

3. Point at Which Sample is Drawn. Although the preponderance of mentally-disordered persons in jails has been interpreted as evidence confirming the criminalization hypothesis (Whitmer, 1980; Lamb and Grant, 1982), research conducted at this level in the criminal justice process has inherent sampling biases. For example, investigations of jail populations eliminate those mentally-disordered persons who may be arrested but are diverted from the criminal justice system to a mental health facility during arraignment or the pretrial hearing. Still another problem with research conducted at this level of the criminal justice system relates to the mode of psychological assessment. Unless the assessment instrument measures both past and present symptomatology, it is not possible to

differentiate between persons who were exhibiting signs of mental disorder as a result of the stresses of the incarceration experience and those who were suffering from mental disorder prior to their incarceration.

In sum, while it is possible that the jail has become the poor person's mental health facility, particularly in light of the decreasing availability of treatment services, the aforementioned deficits in previous research preclude a more definitive answer. A study must be designed so as to avoid the problems inherent in using official statistics or retrospective data, narrow sampling criteria, and biased sampling procedures. Moreover, an adequate test of the extent to which the mentally ill are criminalized must take place at the beginning of the criminal justice process, prior to any diversion and before the stresses of the criminal justice process take their psychological toll.

In light of these factors, a logical first step in empirically testing whether or not the mentally ill are being criminalized is to focus on the initial decision in the criminal justice process -- the decision to arrest. Perhaps the most straightforward way to investigate this problem is to observe police involvement with the mentally ill and, in so doing, to ascertain the extent to which the presence of mentally-disordered behaviors enhances the probability of arrest. In other words, other things being equal (i.e., for similar types of situations), are persons exhibiting signs of mental disorder disproportionately arrested? Surprisingly, the criminalization issue has yet to be tested in this manner. Although there have been several studies of police handling of the mentally ill (cf. Urmer, 1973; Matthews, 1970; Bonovitz & Bonovitz, 1981; Bittner, 1967; Rock et al., 1968; Monahan et al., 1979), there has been no large-scale investigation comparing the probability of arrest for mentally-disordered versus non-mentally-ill persons. The study presented in this chapter was designed to correct this omission and, in so doing, provide needed data which may be used to suggest directions for public policy modifications.

Only a portion of the data base is relevant to the research question and will be presented. There were two exclusionary criteria. First, since the focus of this chapter is on the relative arrest rate of the mentally ill, only incidents which had an overall incidence of arrest high enough to permit meaningful comparisons were included. As a consequence, two major incident categories were deleted from all tabulations: (a) 310 traffic offenses involving 433 citizens (arrest rate=0.9%); and (b) 188 public-service incidents involving 324 citizens (arrest rate = 0.0%). In sum, of the 1,382 police-citizen encounters originally observed, a total of 498 encounters involving 757 citizens were eliminated from the present analysis, resulting in a data base of 884 encounters involving 1,798 citizens.

Second, in order for an arrest to take place at the time of the encounter, there must be a suspect present at the scene, as well as tangible evidence of a citizen's wrongdoing such that they are defined by police to be a suspect. Obviously, only a portion of the observed police-citizen encounters fulfill these criteria. In this study, of the 1,798 citizens involved in the 884 police-citizen encounters, 506 were suspects (as defined by police). This chapter will present an analysis of the arrest rates of the 506 suspects.

Findings

Arrest was found to be a relatively rare event, occurring in only 110 (12.4%) of the 884 encounters. Expressed in individual terms, 506 of the 1,798 citizens involved in the encounters were suspects, and of these, 148 (29.2%) were arrested. (The number of suspects arrested is larger than the number of encounters involving arrest because some encounters resulted in multiple arrests.)

The major question to be addressed is whether the presence of symptoms of mental disorder affect the probability of arrest. Of the 506 suspects, 30 (5.9%) were considered by the fieldworkers to be mentally-disordered. Table 1 presents the crosstabulation of the presence of symptoms of mental disorder and arrest. This table shows that the probability of being arrested is nearly 20% greater for suspects exhibiting signs of mental disorder than for those who apparently are not mentally ill. Fourteen of the 30 mentally-disordered suspects were arrested (46.7%), as opposed to only 27.9% (133 of 476) of the suspects who showed no signs of mental disorder; chi-square (1,N = 506) = 4.801, $p < .05$; chi-square (1,N = 506) = 3.936 (corrected for continuity), $p < .05$.[1]

One possibility for this data pattern is that the greater incidence of arrest among the mentally-disordered suspects may be less a reflection of criminalization, than of a propensity to be involved in serious crimes having a high arrest-rate. In order to pursue this line of investigation, Table 2 presents the crosstabulation of the presence of mental disorder by arrest, controlling for incident type. [2]

Table 2 shows that the arrest rate for mentally-disordered suspects is higher than that for non-mentally-ill persons within every category of offense except interpersonal conflict. In sum, under the assumption of ceteris paribus i.e., within similar types of situations, persons exhibiting signs of mental disorder have a higher probability of being arrested than those who do not show such signs. Clearly, the way we treat our mentally ill is criminal.

There are two possible explanations for the higher arrest rate among mentally-disordered citizens. First, and most obvious, arrest may be used by police as a way of "handling" the mentally-disordered person via criminalization. Alternatively, the police may not recognize persons as mentally ill, i.e., arrest may be used as a disposition because of the officer's lack of knowlege concerning the signs and symptoms of mental disorder. In order to investigate this latter possibility, two other analyses were run. First, the fieldworker's judgment of the suspect's mental disorder was compared to that of the police officer's.[3]

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[1]It must be noted that if all incidents were included in the analysis, the difference in arrest rates would be in the same direction, and would be much greater than depicted in Table 1. chi-square (corrected) = 16.10, df = 1, $p < .001$.

[2]This typological system was adapted from Feeley (1979); the seven categories were derived from over 120 coded incident-types. "Violent personal crimes" included homicide, rape and serious assault. In contrast, less serious disturbances between persons were coded as "Interpersonal conflicts." "Crimes against property (major)" differed from "minor property" crimes in that incidents coded in the former category involved the presence of a weapon, (i.e., robbery) or a theft of felonious magnitude. "Public health, safety or decency" included all drug offenses, as well as offenses violating the normative order, e.g., prostitution, gambling, etc. Incidents coded as being "Crimes against public order" involved some type of minor disturbance, e.g., "disorderly" persons, public intoxication or vagrancy, "suspicious persons/situations," etc.

[3]When two officers were present in the encounter, a judgment of mental disorder by either officer was sufficient to classify the citizen as "disordered".

There was a moderate to strong association betwen the fieldworker's assessment and that of the police; Goodman and Kruskal's Tau = .485; Kendall's Tau-b = .696, Yule's Q = 1.0. The fieldworker and police officer agreed on the apparent mental status of the suspect in 491 or 97.0% of the cases. However, what is crucial to the analysis is the direction of disagreement. In all cases, the discrepancy between officer and fieldworker was one of underidentification by the officer, i.e., the officer failed to identify a person as mentally disordered who was so labeled by the fieldworker. Of the thirty suspects defined as being mentally disordered by the fieldworker, only 15 (one-half) were detected by the officer. However, there seems to be little or no difference in the arrest rate of mentally-disordered suspects in terms of the police officer's perception of their mental status. Six of the 15 suspects (40%) whom the police thought were mentally ill were arrested; of the fifteen suspects whom police did not recognize as being disordered, eight (53%) were arrested. Thus, the propensity to arrest mentally-disordered persons shown in Tables 1 and 2 may be a result, at least in part, of the officer's lack of knowledge of the symptoms of severe mental disorder.

There are several possible explanations for the higher arrest rate among persons exhibiting signs of serious mental disorder. First, many mental disorders include a number of symptoms which, particularly for the psychologically naive, can be rather disconcerting. Although the more annoying symptoms of mental disorder (e.g., verbal abuse, belligerance, disrespect) are not by themselves violations of any laws, such behaviors may provoke a harsher response by the police officer. Thus, mental disorder can preclude a socially-appropriate response by the citizen in an encounter with the police, which may result in a more punitive disposition (i.e., arrest). In short, given that acts of disrespect to a police officer are enough to increase the probability of arrest for "normal" persons (i.e., those who are not mentally-ill) (Black, 1980), it is possible that such behavior on the part of a mentally-ill person would provoke a similarly punitive response (see Chapter 1).

Second, the data pattern may be an indication of the burgeoning interstices between the various health care delivery systems. The drastic funding cuts in mental health programs have resulted in severe reductions in service, both inpatient and outpatient (NIMH, 1983). As a result, the criminal justice process may have become the default option for disposition of persons who are not able to be treated within the mental health system. The qualitative data from the present investigation provide support for this interpretation of the data. In the present study, it was common practice for police to obtain a signed complaint in situations where the person was thought by police to require psychiatric hospitalization. The logic underlying this procedure was to ensure the ready availability of an alternative disposition (arrest) in the event that the hospital found the individual unacceptable for admission. The police officers' apparent ingenuity was clearly born out of necessity, since hospitals have very specific criteria for admission. The qualitative data indicated that virtually every police officer was aware of the rather stringent requirements for admission into the local psychiatric hospital: the individual must be seriously ill, that is, actively delusional or suicidal. Police knew that persons who were mentally retarded, alcoholic or defined by hospital staff to be "dangerous" were persona non grata at the hospital. It was common knowledge among officers that if the citizen did not fit the above-mentioned criteria, another disposition was needed.

The requirements of policing are to handle situations such that the officer is not required to return to the scene (Bittner, 1967). As a

consequence, arrest is often the only disposition available to the officer in situations where persons are not sufficiently disturbed to be hospitalized, yet are too public in their deviance to be ignored. Similarly, in situations where the person is defined to be "too dangerous" for the hospital, arrest is the only disposition available to the officer. The irony is that it is precisely the requirements for emergency psychiatric detention set forth in most mental health codes ("dangerous to self and others") which render the citizen "undesirable" by some hospitals, and result in their arrest.

The qualitative data also indicated that persons who exhibit symptoms which cross the boundaries of the various caretaking systems are also arrested. This appears to be a function of the overall configuration of the health delivery system. Our public health system is comprised of a rather fragmented assortment of components. Although a complex array of services is available, each sub-system designs its programs to fit a specific need; the majority of programs are designed as if clients were created as pure types. For example, most mental health programs find persons with alcohol problems to be disruptive to the patient milieu, and often will not accept them for treatment (see Chapter 1). Conversely, detoxification facilities are seldom equipped to deal with persons exhibiting signs of mental disorder and will turn away persons with such "mixed" symptomatology. Unfortunately, as a result of the narrow parameters of each of the various sub-systems, a number of persons will not be accepted for treatment in any health care facility. Again, this was confirmed by the qualitative data. Police officers would often make the rounds of the various service agencies -- from halfway house to hospital to "detox" -- before resorting to the disposition of arrest. Thus the criminal justice system may have become the "court of last resort" (Warren, 1982) because, unlike other agencies, it has no requirements or restrictions for entree. In short, persons deemed inappropriate for one or another health service may be processed through the system that can't say no: the criminal justice process.

In sum, the data presented here provide some confirmation that the mentally ill are being criminalized, in that mentally-disordered persons had a significantly higher arrest rate than those who were not mentally disordered. This trend is of concern because the criminal justice system was not designed to be a major point of entry into the mental health system. Although diversion to a mental health facility can, in theory, be ordered during the pre-trial hearing, judges are trained in matters of jurisprudence, and are not sophisticated psychological diagnosticians. While some mentally-ill persons may be diverted during pre-trial hearings and transferred to a psychiatric facility, it is likely that many truly disordered individuals are not detected. Once incarcerated, the jail is a less than ideal treatment center for the mentally ill. Psychiatric resources within jails range in both quality and scope (Morgan, 1982). Moreover, the cacaphony of the jail setting mitigates against the recognition of mental disorder. Still another problem with using the criminal justice system as the point of entry for mentally-disordered persons is that being initially labeled as "criminal" via arrest may doom such persons to be similarly relabeled (i.e., arrested) in future acts of disorderliness.

Aside from the rather obvious humanitarian issues raised by these findings, the results also call into question the prevailing political philosophy regarding the level of mental health funding. It seems likely that cuts in psychological treatment services are not without concomitant costs in other areas. If the criminal justice system has indeed evolved into being a point of entry for psychiatric treatment, this would suggest that budget reductions in the mental health area may have shifted the financial burden to an alternative institution, the jail and/or prison. It may be no coincidence that the number of persons in jails was one third higher in 1982

than in 1978 (U.S. Department of Justice, 1983a). The pattern is similar in the nation's prisons: the overwhelming trend is one of upward growth, only one-half of which is a result of an increase in general population (U.S. Department of Justice, 1982). In 1982, there was an annual increase of nearly 43,00 inmates, the highest in any year since data were first recorded in 1925 (U.S. Department of Justice, 1983b). However, the results of a recent investigation point to the fact that the growth in prison populations cannot be attributed solely to the admission of prior mental patients who, in a previous era, might have remained hospitalized (Steadman, Monahan, Duffee, Hartstone, & Robbins, in press). Further evidence that the prisons are unlikely repositories for the severely mentally ill can be found in the pattern of criminal offenses committed by the mentally ill. In the present study, only four of the thirty mentally-disordered citizens committed crimes serious enough to result in long-term incarceration (see Chapter III), a pattern consistent with previous studies of the relative criminality of the mentally ill (Monahan and Steadman, 1983). These findings suggest that the jail (rather than the prison) may have become a "revolving door" for the chronically mentally-ill person. Clearly, further investigations of intersystem processing are required in order to confirm the extent to which criminalization has supplanted psychological treatment.

Public Policy Recommendations

This research provides some preliminary evidence that the mentally ill are being criminalized. Since the data are not longitudinal, this finding cannot be interpreted as being indicative of an overall trend toward criminalization. Indeed, there is some anecdotal information indicating that police have traditionally "managed" at least some mentally-ill persons via arrest (Urmer, 1973; Rock et al., 1968; Mathews, 1970; in contrast, see Bittner, 1967). Nevertheless, the results suggest that several modifications of public policy are needed.

First, police officers must receive adequate training in recognizing and handling the mentally ill, such that persons who are more disordered than disorderly may be handled humanely and channelled through the most appropriate system. To this end, the police must have a clearly defined set of procedures to handle mentally-disordered persons, including negotiated "no-decline" agreements with hospitals. In this way, police will have a specific place to bring apparently mentally-disordered citizens for evaluation and/or treatment, and the designated hospital has the mandate to provide psychological assessment and/or treatment. No-decline agreements are vital for establishing a successful liaison between police departments and the mental health system, and will virtually eliminate the problem of hospitals refusing to treat persons who do not meet their sometimes narrow criteria for treatment.

Second, it is recommended that the least restrictive alternative be utilized, and that, wherever possible, persons with misdemeanor charges pending be treated within a mental health facility. This recommendation is consistent with that of the American Bar Association Guidelines which state that, if an apparently mentally-disordered citizen is charged with a misdemeanor, a noncriminal disposition should be obtained (American Bar Association Criminal Justice Mental Health Standards, provisional, 1983). In this way, mentally-ill persons will not become the victims of their own disorder, unless they commit serious crimes which require immediate criminal processing.

Third, treatment systems must be designed so as to eliminate or at least reduce the interstices between the various caregiving systems. Service providers must recognize that many patients are not "pure types," and programs must be set up to treat patients with multiple problem areas. A more integrated system of caregiving should reduce the numbers of persons who fall through the cracks into the criminal justice "net."

Fourth, modes of care other than hospitalization must be implemented in order to provide sufficient alternatives for police referral of mentally-disordered persons. Surprisingly, this recommendation is contrary to current practice. Despite the proven efficacy of alternatives to inpatient treatment (Kiesler, 1982a), we are currently in a situation in which the implementation of such treatment programs lags far behind their development (Kiesler, 1982b). This is particularly unfortunate since the availability of integrative and effective treatments are likely to reduce the probability of a mentally-disordered person coming under the purview of the criminal justice process. Clearly, those methods of treatment found to be more effective than hospitalization must be implemented, and the alternatives available for treating the mentally-disordered offender expanded.

Although the abovementioned recommendations require an increase in current levels of funding, it is likely that such a plan would be financially prudent in the long term. Certainly, the previous practice of deinstitutionalizing mental patients with only a modicum of community-based support (Bachrach, 1976) does not seem to have decreased the rate of hospitalization. Although inpatient care has decreased dramatically in state and county hospitals, the overall rate of hospitalization for mental disorder (i.e., taking into account county, state, private, and general hospitals), has continued to increase well in excess of the population. Moreover, inpatient treatment for mental disorder comprises a substantial proportion (25%) of total hospitalization days in the United States (Kiesler, 1982b). Similarly, the Department of Defense CHAMPUS program recently reported an increase of 25.7% in cost per inpatient admission during the past six months alone. This increase has particular relevance for psychological health care and delivery given that between 70 and 80% of all mental health expenditures are for inpatient care (DeLeon & Vandenbos, 1983).

Nor is this trend likely to change in the near future. Kiesler et al. (1983) estimate that chronicity has substantially increased over the years. While this increase is due, in part, to deficiencies in the current systems of care, it is also the result of the changing demographic characteristics of the population. The greater proportion of younger persons in the population has resulted in a dramatic increase in the incidence and prevalence of schizophrenia, which is primarily a disorder of the young (Kiesler et al., 1983). Clearly, the overall trend is one of increased consumption of mental health services.

Despite this trend, changes in federal policies have been in the direction of reducing both funding levels and federal involvement in mental health programs. For example, the Omnibus Reconciliation Act of 1981 (PL 97-35) resulted in a 25% reduction in funds for mental health services, and the Mental Health Systems Act (1980) has been repealed. More important, changes in Medicaid have reduced the federal contribution to services (Kiesler et al., 1983). These reductions in funding may have serious consequences for the deinstitutionalized person. It is likely that maintaining support for mental health programs at current levels will increase the probability that mentally-ill persons publicly exhibiting their disorder will be processed through an alternative system of social control, the criminal justice system.

In conclusion, the mentally ill must not be criminalized as a result of inadequate funding for the mental health system. The necessary fiscal commitments must be allocated to implement the proven technological innovations in mental health treatment. It is thus encouraging that the Senate recently recommended an increase in the appropriation for mental health training, specifically citing the need for training professionals to treat the increasing numbers of citizens who are incarcerated in the nation's jails (U.S. Senate Report No. 98-247, 1983). However, this

recommendation is a necessary first step of many, and a long-term commitment to funding mental health care is required. In this way, the most appropriate and effective treatment programs may be provided within the least restrictive setting possible. We must make policy modifications and allocate the appropriate resources in order to see that the civil rights of the mentally ill are protected and, in so doing, provide the most humane and effective treatment available.

Table 1

Relationship Between the Presence of Mental Disorder and Arrest

	Presence of Mental Disorder		
Arrest	No	Yes	Total
No	343	16	359
(%)	(72.1)	(53.3)	(70.9)
Yes	133	14	147
(%)	(27.9)	(46.7)	(29.1)
Total	476	30	506
	(94.1)	(5.9)	

Chi-Square = 4.801 with 1 degree of freedom

$p < .05$

Chi-Square (corrected for continuity) = 3.936 with 1 degree of freedom

$p < .05$

Table 2

Comparison of Arrest Rates for Mentally-Disordered/Non-Mentally Disordered Suspects Within Basic Incident Types

	Nature of Incident						
Presence of Signs of Mental Disorder	Violent Personal Crimes	Interpersonal Conflict	Major Property Crimes (felonies)	Minor Property Crimes (misdemeanors	Public Health Safety, or Decency	Public Order	Total
No	58.8%	14.9%	83.3%	61.2%	60.9%	20.7%	
(N)	(10)	(22)	(10)	(30)	(14)	(47)	133
Total	17	148	12	49	23	227	476
Yes	100.0%	11.1%	100.0%	100.0%	100.0%	46.7%	
(N)	(3)	(1)	(1)	(1)	(1)	(7)	14
Total	3	9	1	1	1	15	30

The Criminality of the Mentally Ill: A Dangerous Misconception

In recent years, there has been a substantial increase in the number of mentally-disordered persons residing in the community (NIMH, 1984). This increase is a result of a number of complex factors including deinstitutionalization, more restrictive laws regarding commitment, and fiscal reductions in mental health programs (Teplin, 1983). Unfortunately, the successful re-entry of the mentally-disordered person into the community may be hampered by the longstanding stereotype of the mentally-ill individual as being "dangerous" (Shah, 1975; Schag, 1977; Rabkin, 1979; Fracchia et al., 1976; Olmstead & Durham, 1976; Mechanic, 1969; Nunnally, 1961; Steadman & Cocozza, 1978).

A crucial issue is whether the stereotype of the mentally ill as "dangerous" and, therefore, more prone to crime is warranted. One way to empirically verify the "dangerous" stereotype is to observe police-citizen encounters (both police-initiated and citizen requests for service) and tabulate the relative frequency and types of crimes committed by persons exhibiting signs of serious mental disorder with that of non-mentally-disordered individuals. This chapter, based on quantified data from an observational study of 1072 police-citizen encounters, presents the results of such an investigation and, in so doing, provides needed data on the relative criminality of the mentally ill.

Teplin, Linda A. The criminality of the mentally ill: A dangerous misconception. American Journal of Psychiatry 142(5), 593-599, 1985.

Previous Research

With relatively few exceptions, the bulk of research in this area has attempted to verify the relative dangerousness of the psychiatric patient by comparing the arrest rates of former mental patients with those of the general population. Earlier investigations found either lower or equivalent arrest rates among former mental patients than in the general population (Ashley, 1922; Pollock, 1938; Cohen & Freeman, 1945; Brill & Malzberg, 1962). In contrast, most of the later investigations (Rappeport & Lassen, 1965, 1966; Giovannoni & Gurel, 1967; Zitrin et al., 1976; Durbin et al., 1977; Steadman , Cocozza & Melick, 1978; Steadman, Vanderwyst & Ribner, 1978) found a higher arrest rate among formerly hospitalized persons than the general population.

Steadman and his associates offer a rather intriguing explanation for this apparent inconsistency over time (Steadman, Cocozza & Melick, 1978; Steadman, Vanderwyst & Ribner, 1978). They found that the number of mental patients with prior arrests has increased substantially over the years, and posited that the apparently higher arrest rate among former mental patients is a result of the marked change in the clientele of state hospitals. Steadman, Vanderwyst and Ribner (1978) pursued this line of investigation by comparing the rearrest rates of patients with and without criminal records. The results were striking: those patients without arrest records (approximately three-quarters of their sample) were arrested infrequently, i.e., at virtually the same rate as the general population. In contrast, it was the patients who had multiple arrests prior to their psychiatric hospitalization who were more likely to be rearrested subsequent to their hospital discharge. Steadman, Vanderwyst and Ribner (1978) concluded that it was not prior criminality per se that resulted in mental patients being arrested more often than non-mental patients, but the increased

numbers of patients entering psychiatric facilities with criminal records. The lack of relationship between prior hospitalization and subsequent arrest was also replicated in another investigation using an offender population (Steadman & Ribner, 1980). In this study, Steadman and Ribner reported no relationship between the existence of a prior mental hospitalization and subsequent arrests made within 18 months after the offenders were released. To date, the only study finding higher arrest rates among former mental patients with no prior arrest record is an investigation conducted in California by Sosowsky (1980). Although he reported arrest rates for former mental patients more than five times those of the general population, the study has been severely criticized for using inappropriate baseline data (Monahan & Steadman, 1983), thus rendering Sosowsky's conclusions somewhat suspect.

In sum, the latest research literature indicates that the apparent greater criminality of former mental patients found in the more recent investigations can be attributed to a difference in the characteristics of the sample utilized in the earlier and the more current investigations (Steadman, Cocozza & Melick, 1978). When samples are matched for demographic factors and prior criminal history, there is no consistent evidence that the true prevalence rate of criminal behavior among former mental patients exceeds the true prevalence rate of criminal behavior among the general population (Monahan & Steadman, 1983). However, while the logic of this argument is compelling, the conclusion that the mentally ill are no more prone to crime is rendered problematic by several methodological limitations of the previous research.

(1) Type of Data.

Previous investigators have largely relied on official arrest-rate statistics as a measure of criminal behavior. This procedure, whereby data can be efficiently collected on a large number of cases was necessitated by the current state of knowledge in the area. Unfortunately, the value of such archival information is compromised by three basic problems.

First, although arrest rates are one important index of "true" criminal behavior (Monahan & Steadman, 1983), this operationalization has a serious limitation. By using arrest as the sole indicator of "crime", such studies eliminate those "truly" criminal incidents which result in the presence of the police, but do not culminate in an arrest. Criminological research indicates that, even in situations in which criminal acts have occurred, informal dispositions predominate and arrest is a statistically rare event (Reiss, 1971; Manning, 1977; Black, 1980). As a consequence, studies based on arrest rates capture but a fraction of those "crimes" that occur, and thus severely underrepresent the "true" prevalence of criminal behavior. What is needed is a data collection plan that captures a greater proportion of criminal events.

Second, the value of arrest-rate statistics is further compromised by the fact that arrests are by no means a "random" sample of all criminal events. The decision to arrest is the result of a complex discretionary process in which the commission of a crime is only one determining factor. Again, this is substantiated in the criminological literature. For example, arrest decisions have been found to be related to the prior arrest record of the suspect (Thomas & Sieverdes, 1975; Blankenship & Singh, 1976), the perceived helplessness of the citizen (Nimmer, 1971) and the mental status of the suspect (Teplin, 1983). The fact that non-criminological variables may intrude into the decision to arrest may result in a severe sampling bias in studies using arrest-rate statistics. For example, the finding of Steadman, Cocozza, & Mellick (1978) that arrest rates vary for former mental patients

with and without a previous arrest record may be less a function of the lesser criminality of mental patients than of the apparent inclination of police to arrest prior offenders.

Finally, when using official statistics, the category of crime may have only a vague resemblance to the actual nature of the criminal event. For example, domestic disputes which often involve assault and/or battery rarely result in an arrest for either of these crimes. If an arrest occurs (in itself a rare event), the charge is most often "disorderly conduct", a lesser offense which has the function of temporarily removing the offender from the scene of conflict (Black, 1980).

In sum, arrest rates cannot be equated with the commission/non-commission of a crime, nor can the type of charge be taken to reflect the actual nature of the criminal event. As a consequence, relying on arrest-rate statistics as the sole indicator of "true" criminal behavior is likely to result in a biased sample of "crimes." The matter is further complicated by the fact that the direction of this bias is unknown. On the one hand, mentally-disordered persons may be more likely to be arrested than the non-mentally-ill for similar offenses, particularly in situations where there is a paucity of alternative dispositions available to the officer (Teplin, 1983). This would have the effect of making the mentally ill appear to be more criminal (i.e., have a higher arrest rate) than they "really" are. Alternatively, studies using arrest rates may underestimate the amount of crime committed by the mentally ill, particularly since those with a history of previous hospitalizations are often rehospitalized rather than arrested (Rabkin, 1979). Clearly, what is needed to assess the relative criminality of the mentally ill is a data base encompassing a more representative sample of criminal offenses than do arrest-rate statistics.

(2) Type of Sample.

Virtually all investigations have used prior hospitalization as the sole indicator of mental disorder. Moreover, with the exception of one study of prior offenders (Steadman & Ribner, 1980), all investigations have restricted their samples to persons who have been hospitalized in a state institution. There are two problems inherent in this sampling procedure.

First, if only persons from state hospitals are included, the sample, by definition, eliminates private patients. Monahan and Steadman (1983) point out that this sampling strategy biases the results in the direction of finding greater criminality among former mental patients. They reason that rates of criminal behavior might be expected to be higher for former state hospital patients than among the entire group of formerly-hospitalized persons (both public and private). Persons treated in state hospitals tend to be of a lower social class than those treated as outpatients or in private facilities, and many studies find a correlation between criminal behavior and lower social class (Monahan & Steadman, 1983).

Second, this rather restrictive sampling strategy excludes those mentally-ill persons who due to a lack of sophistication, community resources, or pure happenstance are not given inpatient treatment. Here the problem is one of external validity; it would be desirable to extend the findings of the previous research to samples other than an inpatient population. What is needed is to base the operationalization of mental disorder less on treatment (i.e., former mental patients) than on broader indicators of mental illness.

In conclusion, what is needed to move beyond the previous research literature is a study designed so as to avoid the aforementioned problems inherent in using arrest-rate statistics and restrictive sampling criteria. A logical extension of the body of research in this area is to focus on the initial point in the criminal justice system --the police-citizen

encounter. In this way, we may ascertain the actual frequency of criminal acts committed by mentally-disordered persons, as well as compare the relative incidence of crimes committed by persons exhibiting signs of mental disorder with baseline data (i.e., non-mentally-disordered individuals). In so doing, this chapter presents additional evidence needed to ascertain the relative criminality of mentally-disordered persons.

Results

Overall, police encounters with mentally-disordered persons were a relatively rare event; of the 2,122 persons involved with police, only 85 or 4.0% exhibited signs of serious mental disorder. A major question is whether persons suffering from mental disorder were predominantly suspects or victims of crimes. Table 1 tabulates the presence of mental disorder (yes/no) by the role of the citizen; $\chi^2 = 44.78$. $p < .001$. This table shows that mentally-disordered persons are far less likely to be victims or complainants than non-mentally-ill individuals, but are twice as likely as non-mentally-disordered persons to be either subjects of concern or objects of assistance. In addition, they are somewhat more likely (35.3% versus 23.4% for non-mentally-disordered persons) to be suspects.

The next step in the analysis was to ascertain the extent to which mentally-disordered suspects were involved in the more serious crimes. Table 2 presents the type of incident by the presence/absence of mental disorder for the 506 suspects; $\chi^2 = 4.58$, n.s.* These data indicate that mentally-disordered persons do not differ significantly from non-mentally-ill individuals vis-a-vis the type of law-violative act.

In sum, the data indicate that the mentally ill do not present an overwhelming burden for police in terms of frequency of encounters. More important, while they exhibited a slight, albeit nonsignificant trend to be suspects more frequently than non-mentally-disordered persons, they do not commit serious crimes disproportionate to their numbers. From these data, it appears that the pattern of crime is substantially similar to that of the general population, at least in this large northern city.

Conclusion

This chapter shows that contact with mentally-disordered citizens was a relatively infrequent event; mentally-disordered citizens comprised less than 5% of persons who were involved with the police. This figure is within the expected range based on recent epidemiological studies of the true prevalence of serious mental disorder in the United States. Estimates of the rates of psychoses in community populations range from 0.0% to 8.3%

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* These seven categories were derived from sixteen major incident types which were reduced from over 120 subcategories. "Violent personal crimes" included homicide, rape and serious assault. In contrast, less serious disturbances between persons were coded as "interpersonal conflicts." "Crimes against property (major)" differed from "minor property" crimes in that incidents coded in the former category involved the presence of a weapon (i.e., robbery) or a theft of felonious magnitude. "Public health, safety or decency" included all drug offenses as well as offenses violating the normative order, e.g., prostitution, gambling. In contrast, incidents coded as being "crimes against public order" involved some type of minor disturbance, e.g., disorderly persons, public intoxication or vagrancy, suspicious persons/situations. Incidents initially coded in multiple categories were later recoded according to the more serious incident.

(Neugebauer et al., 1980), and the median rate is 1.7%. Although the frequency of police involvement with the mentally ill is higher than the median prevalence rate of psychosis, this may be explained by the characteristics of the neighborhoods which were studied. Specifically, the data collection site included two "deviant ghettos" (Scull, 1977), i.e., neighborhoods which contained a number of halfway houses and residential hotels housing former mental patients. In communities such as this, one would expect the number of contacts with police to be somewhat higher than the median rate found in the national epidemiological studies.

However, contact between a mentally-disordered person and the police was not likely to be a result of their committing a crime. Mentally-ill persons were involved as suspects only slightly (and non-significantly) more often than would be expected by their numbers. The modal involvement between police and the mentally ill was not one of a crazed suspect committing a heinous crime, but was more likely to involve a person engaging in behavior harmful to him or herself. These findings thus confirm the use of police as a major community mental health resource (Bittner, 1967; Matthews, 1970; Teplin et al., 1980; see also Chapter I). Clearly the police officer operates, at least to some extent, as a street corner psychiatrist. Put in this context, there is ample reason to expect the mentally ill to have contact with the police inasmuch as they represent one of the "needier" segments of the population.

Perhaps the most important finding of this chapter is that there were no appreciable differences between the mentally-disordered suspects and the non-mentally-disordered suspects regarding the type of crimes that were perpetrated. This result is inconsistent with many of the previous investigations using arrest-rate data. One explanation for this discrepancy may be the unique methodology used in this study. Previous research has relied largely on archival data, e.g., studying the arrest records of former mental patients. As mentioned earlier, there is great potential slippage between the commission of a law-violative act and that incident being labeled as a crime via arrest. Only a small proportion of criminal incidents actually "become" crimes (i.e., result in arrests). In the present study, for example, only 29.2% of the 506 suspects were actually arrested (see Chapter II). Moreover, law-violative acts that result in arrest are neither a random nor representative sample of crimes that occur. The decision to arrest is known to be influenced by a variety of socio-psychological and socio-structural exigencies (Black, 1980). Labelling theorists suggest that initially bestowed definitions such as "prior offender" and "mental patient" become a type of master status that substantially affects the ways in which that person's subsequent behavior is defined, interpreted and processed (cf. Rosenhan, 1973; Becker, 1963). Since labels such as prior criminal record and the presence of obvious symptoms of severe mental disorder are known to increase the probability of arrest (see Chapter II), the apparently greater criminality of the mentally-ill found in the arrest-rate studies may be an artifact of their propensity to be arrested rather than a tendency towards criminality per se.

It is interesting to note that these data provide indirect support for the position of Monahan and Steadman (1983). In an exhaustive review of the pertinent research literature, they concluded that if a number of socio-demographic factors known to be related to crime are taken into account (e.g., race, age, prior criminality), the relationship between mental disorder and criminality substantially diminishes. This study, unlike previous investigations, encompassed all detected law-violative acts, regardless of the police officer's disposition of the incident. Thus, it is relatively uncontaminated by the effects of those

variables which Monahan and Steadman feel may have produced an artifactual relationship between mental disorder and criminality. The results of this study indicates that future investigators should attempt to design studies so as to avoid the biases inherent in archival data.

In conclusion, the stereotype of the mentally ill as dangerous is not substantiated by data from police-citizen encounters. Thus, it is particularly unfortunate that the mentally ill continue to be portrayed by the news and entertainment media as crazed and violent people. Selective media reporting of instances in which mental illness and criminal behavior appear to be linked feeds the stereotype of the mentally ill as dangerous (Steadman & Cocozza, 1978). Similarly, producers of video entertainment (both television and movies) appear to be addicted to "mad slasher" plots in which grizzly crimes are almost invariably committed by a newly-released mental patient. One wonders if such meta-evidence is responsible for the recent proliferation of the more combative tactics (e.g., nets, toxic substances) police now use to respond to calls involving mentally-disordered persons (Basler, 1981).

The crucial issue is that with the advent of deinstitutionalization the mentally ill have no choice but to reside within the community. Unfortunately, reintegration into the community is made all the more difficult by the presumption that the mentally-ill person is dangerous and prone to crime (Steadman, 1981). Until such time as this stereotype is substantiated by empirical evidence, we must find ways to correct this misconception and, in so doing, provide a more receptive environment for the re-entry of the mentally ill into the community setting.

TABLE 1

Crosstabulation of Presence of Mental Disorder with Role for 2,122 Citizens

Role	Presence of Severe Mental Disorder: Yes		No		Total	
	Number	%	Number	%	Number	%
Victim/Complainant	13	15.3	653	32.1	666	31.4
Suspect	30	35.3	476	23.4	506	23.8
Witness/Complainant	2	2.4	354	17.4	356	16.8
Subject of Concern	25	29.4	293	14.4	318	15.0
Object of Assistance	14	16.5	163	8.0	177	8.3
Other	1	1.2	98	4.8	99	4.7
Total	85	100.1*	2,038	100.1*	2,122	100.0

* Due to rounding error

$\chi^2 = 44.78$ 5 degrees of freedom $p < .001$

TABLE 2

Crosstabulation of Presence of Mental Disorder with Type of Incident (N = 506 Suspects)

	Presence of Severe Mental Disorder					
	Yes		No		Total	
Type of Incident	Number	%	Number	%	Number	%
Violent Personal Crimes	3	10.0	17	3.6	20	4.0
Interpersonal Conflict	9	30.0	148	31.1	157	31.0
Major Property Crimes	1	3.3	12	2.5	13	2.6
Minor Property Crimes	1	3.3	49	10.3	50	9.9
Public Health, Safety or Decency	1	3.3	23	4.8	24	4.7
Public Order	15	50.0	227	47.7	242	47.8
Total	30	99.9*	476	100.0	506	100.0

*Due to rounding error

$\chi^2 = 4.58$ 5 degrees of freedom

$.25 < p < .50$ (not significant)

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