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Are Jails Replacing the Mental Health System for the Homeless Mentally Ill?

John R. Belcher, Ph.D.

ABSTRACT: The author explores the process of how homeless mentally ill persons become involved with the criminal justice system. The unique demands of homelessness and chronic mental illness were specifically examined in this naturalistically based study. The author concludes that a combination of severe mental illness, a tendency to decompensate in a nonstructured environment, and an inability or unwillingness to follow through with aftercare contributed to involvement with the criminal justice system. Changes in the mental health system that would prevent the criminalization of the homeless mentally ill are suggested.

Deinstitutionalization of state mental hospitals and narrowly defined civil commitment statutes have contributed to an increase in the number of chronically mentally ill persons being incarcerated (Bonovitz & Bonovitz, 1981; Stelovich, 1979; Teplin, 1983). In jail, these individuals often receive little or no treatment and are neglected and ignored (Lamb, 1984). Mentally ill persons who are homeless are particularly vulnerable to frequent involvement with the criminal justice system (Fischer, 1988).

The author researched the path homeless chronically mentally ill persons take into the criminal justice system, and in this paper outlines the research methodology, a naturalistic approach, which was utilized to provide a more complete examination of this phenomenon. He also presents alternatives that will help to prevent these individuals from being inappropriately involved in the criminal justice system.

Dr. Belcher is an Assistant Professor at the School of Social Work and Community Planning, Baltimore Campus, 525 West Redwood Street, Baltimore, Maryland 21201.

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A Closer Look at the Problem

Involvement with the criminal justice system is generally the result of norm violations that the public or police interpret as deviant (Rennie, 1978). Whereas some norm violations may be willful to accomplish a goal, such as robbing a bank to obtain money, other violations may be the result of an inability to fully understand societal norms, to participate in them, and to exercise the internal controls necessary to avoid them. This is the case for many severely mentally ill individuals who cannot adequately manage their lives in a nonstructured environment because of cognitive disorganization resulting from their illness (Harrow et al., 1983).

Several studies have shown that impairment in functioning is exacerbated by life on the streets, short hospital stays, and frequent incarceration in jails (Crystal & Goldstein, 1984; James et al., 1980; Rosnow et al., 1986). These different environments create conflicting demands on the homeless mentally ill resulting in an inability to respond appropriately to life situations.

Street life demands flexibility and mobility as homeless persons attempt to adjust to changing environmental conditions, which are incorrectly interpreted because of cognitive disorganization (Hope & Young, 1986; Baxter & Hopper, 1982). Even if some success is attained in surviving on the streets, hospitalization or incarceration creates a new set of demands. A hospital environment requires discipline and the ability to follow a prescribed routine. The jail demands a third set of skills, the ability to live in close confinement and in overcrowded conditions.

Bachrach (1984) observes that these conflicting environmental demands have shaped the lives of many young mentally persons and has left them without a stable point of reference. The confluence of different environmental demands, impaired judgement, and random movements creates greater confusion, which helps to explain the failure of attempts to involve these individuals in the community mental health system.

Many chronic mentally ill people do not comply with aftercare arrangements when they are released from hospitals and decompensate and wander aimlessly (Belcher & First, 1987–88; Bassuk et al., 1984; Freeman et al., 1979).

The "odd" behavior of many of these individuals and their apparent inabilities to fit into "normative" society leads to a distinct culture with its own identity (Baxter & Hopper, 1982). The uniqueness of this culture and the concurrent distancing from "normative" society places homeless mentally ill people in direct conflict with many norms of

traditional society (Whitmer, 1980). Involvement with the criminal justice system can become more commonplace at this point, in part because of community intolerance of mentally ill persons' behaviors (Rabkin et al., 1980).

An incidence of a higher arrest rate among homeless mentally ill persons may not be indicative of their potential danger to society, instead it more likely reflects the fact that police officers have more frequent contact with these individuals because of minor norm violations, such as jaywalking. Police officers are often in a better position than some mental health personnel to secure for the homeless person a safer environment than the street. (This is particularly true for a homeless mentally ill person who is engaging in behavior, such as wandering in and out of traffic, in which the person is out of touch with reality).

In the past, such an individual might have been committed to a state hospital, but the use of narrowly defined and interpreted civil commitment statutes has made access to state hospitals difficult and the possibility for criminalization greater (Treffert, 1985; Lamb & Grant, 1982). Police officers may determine that a homeless mentally ill person appropriately belongs in a state hospital and subsequently transports the individual to a mental health center for examination. However, in a majority of states if the individual is not overtly suicidal or homicidal he/she will not be given access to the state hospital and the police must decide either to let the person wander back out into oblivion or detain the person in jail (Beiss, 1983).

The options for treating domiciled mentally ill persons, who pose less risk of involvement with the criminal justice system, are much different than the treatment options for homeless mentally ill persons. Unlike the domiciled mentally ill person who is brought into a mental health center by friends or neighbors because of problem behavior and is then released into their custody, homeless mentally ill persons generally have no one who will be responsible for assisting them in the community.

Homeless mentally ill persons involvement with the criminal justice system needs to be understood from the perspectives of police officers, homeless mentally ill persons, and service providers. These multiple perspectives were incorporated into the author's research design, which sought a holistic understanding of homeless mentally ill persons' journeys into the criminal justice system.

METHOD

Beginning in March 1985, all patients cleared for release in the acute care admissions wards of a state hospital located in the Midwest were approached about participating in

the study. Patients who agreed to participate and left the hospital from April to July comprise the sample. Table I show that the demographics of the study sample and total hospital population were similar. The subjects were studied for six months by contacting them at one, three and six month intervals to determine who had become homeless.

The study used a naturalistic research approach that made use of qualitative methods, but moved beyond simply describing the situation to developing working hypotheses that posed possible explanations for the observed phenomenon (Lincoln & Guba, 1985). This method of inquiry is particularly well-suited to understanding the struggles of homeless mentally ill persons and their involvement with the criminal justice system because it seeks to document the life characteristics of individuals in their natural settings.

After respondents were discharged from the hospital, the author verified their discharge information, including a home address. Those persons who could not be found received more intensive tracking, including talking with relatives and neighbors, and contacting various community agencies, including the Social Security Administration. This enabled the author to account for all 132 respondents in the study.

Before the tracking of subjects began, contacts were developed among community informants who had knowledge about homeless persons. These contacts included, homeless shelter staff, soup kitchen staff, and community mental health center staff. Law enforcement personnel who staffed the jail and patrolled the area where homeless persons frequented were similarly contacted and observed to better understand their viewpoints on the arrests of homeless persons.

Interviews with those respondents living in homes were brief and consisted of open-ended questions that sought to determine the respondent's medication compliance, plans for the future, and problems since being discharged from the hospital. This information proved useful in establishing a history of the respondent's life in the community and aided in finding those who became homeless.

Those respondents who became homeless received intensive follow-up interviews; this included contacting the person on a weekly basis. The interview began with the author attempting to establish some rapport with the homeless respondents and then proceeding with open-ended questions that were relevant to the unique context of each individual.

Trustworthiness was accomplished through activities of prolonged engagement, persistent observation, and triangulation (Lincloln & Guba, 1985). The first two activities involved gaining familiarity with the respondents and their contexts by spending considerable time in their "world." Triangulation was accomplished by the use of

Table 1

	Population 306	*Sample 132*
Mean Age	35.26	33.9
Percent Male	58	55
Percent Female	42	45
Percent Black	40	42
Percent White	60	58
Percent Schizophrenic	46	40
Percent Affective Disorder	8	9

multiple resources to confirm information gathered. For example, if a homeless respondent said she was arrested because she attempted to go to China, the social worker at the jail was contacted to verify this information.

Data Analysis

Case files were developed on each person in the study that contained interview information, a chronological record of contact with the respondent, and information obtained from community informants about the respondent. Data to build these files consisted of extensive field notes written after each interview. Tape recorders and direct notetaking during interviews were not used because these methods have been found to frighten homeless respondents (Baxter & Hopper, 1982). At the end of each day, various notes on each respondent were appropriately cataloged and recorded.

The constant comparative method as developed by Glaser and Strauss (1967) was used to analyze the data. This method entails the constant comparing of notes, interviews, and information collected in the process of finding the respondents to determine what categories emerged from the data. As commonalities emerged, overlap was eliminated so the best fit between the category and the respondent was accomplished. From these categories, a series of "working hypotheses" emerged that began to explain why respondents were classified into particular categories.

Context

The study took place in a Midwestern city of approximately 1.5 million people. The number of homeless persons is estimated to be 9,000, including 7,400 adults and 1,600 family members (Metropolitan Human Services Commission, 1984). Industry in this capitol city is dominated by a a large state university, state government, and small manufacturing plants.

The city is served by two large shelters; one accommodates only men, and the other men and women. Several traditional programs and missions operate as well, and they have various requirements, such as attendance at nightly religious services, in order to be given shelter. On average nights, the city-wide shelter census is approximately 350 persons.

The state prefers to treat mentally ill persons in the community. Therefore, State commitment statutes are interpreted in such a way that persons must be overtly dangerous to themselves or others in order to be committed. A state hospital serving a multicounty area is located in the city.

RESULTS

From the total of 132 respondents in the study, 47 persons became homeless. Once the 47 persons were identified as homeless, the author used the constant comparative method to categorize them into groups on the basis of how they became homeless and their type of mental disorder. Four groups emerged from this analysis.

Category I: This category contained individuals who had histories of chronic mental illness and homelessness (n = 33). These individuals suffered largely from biologically based mental illness, such as major

affective and schizophrenic disorders. They became homeless shortly after discharge from the hospital because of the severity of their mental illness, premature discharge, a failure to continue aftercare, and a lack of community supports. They remained homeless for the remainder of the study.

Category II: Five individuals were in this category and, like those persons in Category I, they suffered affective and schizophrenic disorders. Unlike the individuals in the first category, they were able to find homes by the sixth month of the study, and they followed through with aftercare. Their homelessness during the first three months of the study was the result of not being able to function well enough to live in the community without asylum or sanctuary.

Category III: Seven individuals were in this group, and they suffered from either personality disorders or substance abuse. They became homeless for only a short time, and by the sixth month they had homes. Homelessness occurred in this group because of a combination of situational and long-standing personality disturbances. For example, one respondent in this category threatened to hurt herself during a domestic disturbance and was hospitalized. She was discharged to her husband's residence, but he would not allow her to return, which resulted in temporary homelessness.

Category IV: Two individuals were in this group, and they intentionally became homeless to avoid contact with the criminal justice system. They suffered from adjustment disorders and substance abuse. Unlike the respondents in Categories I and II their homelessness did not result for them being severely mentally ill.

A review of the case files for those respondents who became homeless revealed that 23 of them were arrested and jailed during the six month study period. Twenty-one of these individuals were in the first category. The other two respondents who had contact with the criminal justice system were in Categories III and IV. No respondents from Category II had contact with the criminal justice system during the six months of the study.

The author became concerned why a majority, 64%, of the 33 respondents in Category I were arrested and jailed during the study, whereas only two persons who had such contact were included in the other categories. The remainder of the paper will focus on the path the 21 individuals in Category I took into the criminal justice system.

The demographics of these 21 individuals are as follows: 11 individuals were black and ten were white. Seventeen were male and four were female. The mean age of this group was 35.14 and 18 of these

individuals were diagnosed with schizophrenia and three with bipolar disorders.

Among these 21 respondents, a unique pattern emerged that both contributed to their chronic homelessness and to their involvement with the criminal justice system. A review of each respondent's file revealed that community informants, such as police, community mental health personnel, and shelter staff, observed that these 21 respondents were often threatening in their behaviors and exhibited these behaviors in public places. The other 11 individual's files in Category I were reviewed for the same factors and the community informants did not observe these 11 respondents to be threatening or exhibit bizarre behaviors in public places. This is not to suggest that their overall functioning was higher as compared to the 21 individuals in Category I who did have contact with the criminal justice system. Instead, the 11 respondents who had no contact with the criminal justice system were observed to "stay to themselves" and were "quiet."

A review of historical data, from the hospital charts, found that all 33 respondents in the first category experienced severe social functioning in their early adolescence (age 13–14), observations in their psychosocial histories noted that the respondent "did not make sense in class, appeared grossly confused, and could not form social relationships." The other 14 homeless respondents began to experience problems in later adolescence (age 17) and observations in their psychosocial histories noted problems in skipping school, but no notes mentioned that the respondents were confused or had an inability in forming social relationships.

As the 21 respondents who had contact with the criminal justice system grew into young adults their problems with social functioning became more severe, resulting in difficulties in relationships, work, school, and the community. For example, their histories noted the inability to "hold" a job and form social relationships, and the identification by police as "troublesome." Conversations with the 21 respondents confirmed they first came in contact with the police in their early 20s because of "bizarre behavior," such as walking in the community without clothes and talking to themselves. Chart reviews noted that a loss of social supports was triggered because these 21 individuals were unable to learn from the world around them causing peer contact to be increasingly brief. Gradually all 21 individuals became isolated and their social supports were eroded.

All 33 respondents had difficulty working and maintaining themselves in the community without some kind of supervision. Less able to

understand and participate in the world around them, many of the respondents retreated into their own delusional world of safety precipitating more frequent hospitalizations. The mean number of hospitalizations for this group was 12.5 over a five year period. One respondent observed that he began to lose his ability to "hear what the world was telling" him. Psychotropic medication had been prescribed upon their discharges from the state hospitals, but the respondents failed to take their medications and instead chose to self-medicate with alcohol and street drugs.

As their cognitive and social functioning became more impaired, family relationships became even more conflicted and difficult to maintain. This process contributed to further distancing from normative reality. For example 12 of the 33 managed to maintain their Social Security Supplemental Income (SSI) or local welfare, but they were unable to use the money to purchase goods and services. One respondent was observed walking around town with an SSI check in his pocket; however, he did not know how or could not remember how to "cash it." Barter gradually replaced the use of currency; as the respondents became more decompensated the ability to use currency to purchase tangible objects, such as consistent food, clothing, and shelter, became increasingly difficult and wandering the streets in search of basic survival became the norm for these individuals.

The combination of the distancing from normative reality, the high level of frustration, and the confusion resulting from these processes appeared to lead the 21 individuals to commit acts that police officers considered deviant and indicative of mental health problems. Table II shows that the majority of offenses were nonviolent.

It is interesting to note that the 21 respondents who were arrested

Table 2

Type/Arrests	
Child Neglect	9%
Shoplifting	4%
Robbery	9%
Trespassing	9%
Disorderly Conduct	19%
Assault	30%
Petty Theft	14%
Prostitution	4%
Meant number of days in jail = 7.9	

described their activities that led to their arrests with a mixture of delusional material and fragments of reality. A case example from Category I demonstrates the lack of awareness that was common among the 21 respondents who were arrested.

Case Example

Fred is a 33-year-old, white male with a long history of diagnosed schizophrenia. He has been homeless for about three years and his psychiatric onset dates to when he was 24 years of age although his chart notes severe problems in cognition as early as age fifteen. As a young adult, Fred found it difficult to work because he kept getting confused. He would "forget" where he was and what he was supposed to be doing. For example, Fred frequently "wandered off" from home and found himself in another state.

Fred's mother died two years ago, and he became more confused and began to wander further from home. Fred observed, "I knew I was not right but I could not get it together." He was hospitalized 11 times in different states and was usually released after wandering off hospital grounds.

Fred did not take his aftercare medication and became violent when "disturbed" on the street. He collected cans and took them into a bank and demanded money. The bank manager refused and Fred proceeded to throw cans at the bank manager, at which point he was arrested by the police. His growing frustration and confusion between hospitalizations brought him into more frequence with the police.

This case example highlights the cognitive disorganization, disaffiliation, and rootlessness present in the lives of the homeless mentally ill respondents who became involved with the criminal justice system. Their crimes were the result of an inability to understand norms and participate in society. The jail was an asylum of last resort, where they received little or no mental health treatment and were quickly released.

DISCUSSION

The findings suggest that the 21 individuals in the first category became involved with the criminal justice system because of a combination of severe mental illness, a tendency to decompensate in nonstructured environments, and an unwillingness or inability to participate in voluntary aftercare arrangements, and take prescribed medications. Wandering aimlessly in the community, psychotic much of the time, and unable to manage their internal control systems, these people found the criminal justice system was an asylum of last resort.

Responding to the needs of these individuals poses a unique challenge to the community mental health system. The issue of responsibility for the care and protection of these individuals needs to be considered when designing positive treatment alternatives to replace incarceration.

A system that relies solely on voluntary compliance may not provide adequate structure for this population (Gralnick, 1985). Instead, community treatment should be combined with outpatient commitment

and more aggressive follow-up of patients. This approach still maintains an emphasis on treatment in the community, but it recognizes that mentally ill persons with a history of homelessness and who are not compliant in taking their medication need to be closely monitored outside the hospital.

It is important to remember that homeless mentally ill persons are struggling to reintegrate themselves into the community, but they are also in need of structured supports as they seek to resolve that struggle. Criminalization of these individuals appears to be the result of a lack of specific responsibility by a mental health staff person to ensure that the client is not experiencing significant mental decompensation.

The addition of outpatient commitment would create the leverage needed to encourage clients to take their needed medications and also allow for the commitment of those who continued to deteriorate and were in danger as a result. These individuals could be committed to adult foster care homes or similar environments in the community that could provide them with needed asylum and sanctuary (Belcher, 1987). Responsibility for these individuals needs to remain in the mental health system and not be displaced to a criminal justice system that is not designed to appropriately care for the mental health needs of these individuals.

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