Abstract

In this article, I review theory and research on the relationship between mental illness, crime, and violence. I begin by discussing the larger backdrop of deinstitutionalization of mental illness and its consequences for the criminal justice system in both individual and macro-level terms. I then compare public perceptions of dangerousness associated with mental illness with individual-level studies that assess the risk of violence and criminal behavior among those with mental illness. I review key findings as to the role of certain psychotic symptoms, social demographic characteristics, and the context in which violence unfolds. Finally, I discuss recent efforts at managing persons with mental illness who violate the law, focusing on the limitations of diversionary programs.

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1. Introduction

High-profile shootings at schools, universities, and government buildings bring public attention to the problem of mental illness and violence. Visible homeless persons with mental illness and substance abuse problems are commonplace in urban areas. In this article, I provide an overview of the perceptions, realities, and processes surrounding these issues by organizing and reviewing research related to the study of mental illness violence, and crime. Specifically, I address the following questions: How has the nature of mental health care changed in such a way that has led to more people with mental illness in jails and prisons than in hospitals? What are the pathways by which persons with mental illness end up there? What is the public perception of violence among the mentally ill compared to objective assessments of the risk? Finally, how effective are recent efforts at addressing the problem of mental illness in the criminal justice system?

In an effort to integrate our understanding of these issues, I begin by discussing major developments in legal and treatment systems that manage persons with severe mental illness. I then examine recent research on public perceptions of dangerousness among persons with mental illness. Next, I review research on the relationship between mental illness, crime, and violence, focusing on individual, macro, and situational processes. Finally, I discuss recent legal and social policy initiatives related to mental illness and violence.

2. Deinstitutionalization, mental illness, and the criminal justice system

2.1. Deinstitutionalization

Until the 1960s, substantial numbers of persons with mental illness were treated in large, publicly funded hospitals. Based on the National Institute of Mental Health (NIMH) estimates, in 1960, about 563,000 beds were available in U.S. state and county psychiatric hospitals (314 beds per 100,000 persons), with about 535,400 resident patients. By 1990, the number of beds declined to about 98,800 (40 per 100,000) and the number of residents to 92,059 (National Institute of Mental Health, 1990). By 2005, there were only 17 public psychiatric beds available per 100,000 persons, despite increases in the population and estimates that about 50 beds per 100,000 are needed for minimal treatment capacity (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). Several factors contributed to the drop in inpatient capacity. First, medications were developed, which controlled the symptoms of the most debilitating mental disorders (e.g., schizophrenia). Second, an ideological shift, advocating a more liberal position on confinement, led to states adopting stricter legal standards for involuntary commitment (dangerousness to self or others) that are not frequently used. Third, and perhaps most important, fiscal policy changed, including the shifting of costs for mental health care from states to the federal government (Medicare, Medicaid, Social Security Disability Income), followed by budget cuts and substantial underfunding of community mental health services (Gronfein, 1985; Isaac & Armat, 1990; Kiesler & Sibulkin, 1987; Mechanic & Rochefort, 1990; Redick, Witkin, Atay, & Manderscheid, 1992; Weinstein, 1990). These trends and associated policies are generally referred to as the deinstitutionalization of the mentally ill.

The sharp decline in public psychiatric hospital capacity has been offset to some extent by inpatient units in private psychiatric and general hospitals, as well as by moving patients to nursing homes. An important component to the changing nature of psychiatric hospitalization is the increased role of general hospitals. Emergency rooms and psychiatric units in general hospitals provide acute treatment for those with mental illness and can bill Medicaid for doing so (Mechanic, McAlpine, & Olsson, 1998). Although these hospitals contribute to treatment capacity, they still do not provide the longer term care that public psychiatric hospitals did. Moreover, recent studies show changes in how psychiatric hospitalization is accessed, with many disadvantaged patients not admitted to private hospitals because of an inability to pay for their care (Lincoln, 2006). Paradoxically, federal rules prohibit patients aged 21–64 with Medicaid from receiving care in specialized psychiatric hospitals. Therefore, capacity for maintaining and treating America's mentally ill, especially the most severely impaired and economically disadvantaged patients, has been substantially diminished (Ehrenkranz, 2001; Lamb & Bachrach, 2001; Torrey, 1995, 1997).

As hospitals closed and the number of beds reduced, many patients were discharged from state hospitals into the community. Others, as a result of stricter standards for involuntary commitment, were not even admitted—an “opening of the back door” and “closing of the front doors.” Moreover, in the early 1960s the average length of stay was about 6 months, but by the early 1990s it had declined to about 15 days (National Institute of Mental Health, 1990). By 2007, it was less than 10 days. Meanwhile, the rate of admissions from the early to mid 2000s has increased slightly (Manderscheid, Atay, & Crider, 2009). This indicates that patients are often stabilized (i.e., given medication) and released, without adequate follow-up treatment and support (Weinstein, 1990). Not surprisingly, substantial numbers of these patients end up being readmitted. This has been referred to as the “revolving door” phenomenon (Kiesler & Sibulkin, 1987).

Historically, psychiatric hospitals have functioned as a source of control of persons who are unable to care for themselves and whose behavior may be threatening to the social order (Grob, 1994; Horwitz, 1982). In the early 1960s, the public mental health care system crossed a threshold where the majority of expenditures previously directed toward state hospital inpatient care were now directed toward community-based services (Lutterman & Hogan, 2000). An important consequence of reduced hospital capacity is that a large portion of persons with severe mental illness now live in urban areas with less supervision and support. Although some do well, many lack “insight” into their disorders, go untreated, or have difficulty complying with medication regimens, and are unable to support themselves (Mechanic, 2008). This presents considerable difficulties for families and others who are often unable or unwilling to deal with persons whose behavior may at times be unmanageable or threatening (Avison, 1999; Karp, 2001).

2.2. Mental illness and the criminal justice system

Very early research demonstrated the interdependence of the mental health and criminal justice systems (Penrose, 1939). More recently, in the aftermath of deinstitutionalization, prisons and jails have supplanted public psychiatric hospitals as institutions of social control of the mentally ill (Liska, Markowitz, Bridges-Whaley, & Bellair, 1999). Studies have examined frequency of arrest, jail, and imprisonment among people admitted into psychiatric hospitals before and during deinstitutionalization (Adler, 1986; Arvanites, 1988; Belcher, 1988; Cocozza, Melick, & Steadman, 1978; Steadman, Monohan, Duffee, Hartstone, & Robbins, 1984; Steadman, Fabiasak, Dvoskin, & Hoolehan, 1987; Steadman, McCarty, & Morrissey, 1989). Studies from the 1970s and 1980s found that the percentage of patients with prior arrests increased (Arvanites, 1988; Melick, Steadman, & J.J. Cocozza, 1979a; Melick, Steadman, & J.C. Cocozza, 1979b). Studies of imprisonment reported an overall increase in the percentage of prison inmates with prior mental hospitalization (Steadman et al., 1984, 1978). Many researchers thus concluded that the mentally ill are being overarrested and warehoused in city and county jails (Adler, 1986; Lamb & Grant, 1982; Palermo, Smith, & Liska, 1991; Pogrebin & Regoli, 1985; Teplin, 1984, 1990).

More recent nationally representative surveys of state and federal prisoners, jail inmates, and probationers are consistent with earlier
research, indicating that persons who report “currently” or “ever having a mental or emotional condition” are overrepresented in all those groups (Ditto, 1999). One study estimates that up to 16% of persons in jails and prisons may have a mental illness, many of whom have committed serious offenses (Ditto, 1999). That is over 300,000 persons, a rate (for men) which is about 4 times higher than the general population. Thus, it is estimated that there are now more than three times as many persons with mental illness in jails and prisons than in psychiatric hospitals (Torrey et al., 2010). The most recent study puts the estimate of the percentage of inmates with a history of mental health problems in jails at 64% and at 56% for state prison inmates, with 50–60% reporting current symptoms (James & Glaze, 2006). In terms of types of offenses, Silver, Felson, & VanSelltine (2008) found that, among prison inmates, those with serious mental illness were somewhat overrepresented among those incarcerated for assaultive violence and sexual crimes, but not property, and other types of crime. Because of a lack of appropriately trained staff and screening procedures, many persons are retained in jails and prisons without adequate treatment. These inmates are less likely than others to be released on bail, more likely to experience abuse from guards and other inmates, and are at an increased risk of suicide (Torrey, 1995). Thus, corrections facilities serve, in part, as rather dysfunctional alternatives to psychiatric hospitals. Although many jails and prisons provide mental health services, and several communities have programs to divert mentally ill offenders from jail to treatment (discussed below), the availability of these services and programs is limited relative to the need for them (Fisher, 2003; Goldstrom, Henderson, Male, & Manderscheid, 1998; Morris, Steadman, & Veysey, 1997; Steadman, Morris, & Dennis, 1995).

2.3. The role of homelessness

Homelessness is an important pathway to incarceration among the mentally ill. Studies estimate that approximately one-third of homeless persons meet diagnostic criteria for a major mental illness (Jencks, 1994; Lamb, 1992; Shlay & Rossi, 1992). Including substance-related disorders, the figure is closer to 75%. Consequently, surveys of jail and prison inmates find that mentally ill offenders are more likely than other inmates to have been homeless at the time of arrest and in the year before arrest (DeLisi, 2000; James & Glaze, 2006; McCarthy & Hagan, 1991). Because of a lack of community treatment programs and limited staffing (critical for monitoring medication compliance), personal resources, and social supports, many mentally ill homeless persons are at increased risk of police encounters and arrest for not only “public order” types of offenses, such as vagrancy, intoxication, or disorderly conduct, but also for more serious types of crimes, such as assault (Dennis & Steadman, 1991; Estroff, Zimmer, Lachotte, & Benoit, 1994; Fisher, Silver, & Wolff, 2006; Fisher et al., 2006; Hiday, 1995; Hiday, Swanson, Swartz, Borum, & Wagner, 2001; Lamb & Weinberger, 2001; McGuire & Rosenbeck, 2004; Mechanic & Rochefort, 1990; Silver et al., 2008; Teplin, 1994).

The presence of homeless persons and associated public order offenses may be a source of neighborhood disorder, generating fear and reducing social cohesion among neighborhood residents, thus facilitating more serious crime, such as robbery (see Markowitz, Bellair, Liska, & Liu, 2001; Sampson, Raudenbush, & Earls, 1997; Skogan, 1990). High levels of urban disorder, including the visibility of homeless mentally ill persons, has led many cities to take aggressive policing approaches that, at times, may contribute to the overrepresentation of mentally ill persons in jails and prisons.

The vulnerability of homeless mentally ill persons also increases their risk of being the victims of crime, well beyond the rates generally found by the National Crime Victimization Surveys (Cho, Jeanne, Teplin, & Abram, 2008; Dennis & Steadman, 1991; Teplin, McClelland, Abram, & Weiner, 2005). They are easier targets for offenders. Insights from routine activities theory suggest that homeless persons have reduced levels of “capable guardianship” necessary to protect themselves from crime (Felson, 2002; Hagan & McCarthy, 1998). Moreover, the likelihood of victimization among homeless mentally ill persons is increased because of the risks of victimization associated with alcohol use more generally (Felson & Burchfield, 2004). Altogether, mental illness and homelessness creates “criminogenic” situations.

A macro-level study by Markowitz (2006) showed that, across U.S. cities, higher public inpatient psychiatric capacity was associated with fewer homeless persons and lower crime and arrest rates. Moreover, pooled analyses of states from 1980s to the late 1990s showed that increases in the proportion of private, for-profit psychiatric hospital beds was associated with an increase in the size of jail populations as well as suicide rates (Yoon, 2011; Yoon and Bruckner, 2009). The exact effect of reduced public hospital capacity on homelessness, crime, and arrest rates may be difficult to predict however, since this effect likely depends on the availability and quality of a variety of fragmented community-based treatment and housing services, of which data are not systematically compiled in the same way that hospital data is. In these studies, per capita spending on community mental health services shows no effect on crime and arrest rates and is associated with an increase in the size of jail populations, but it offsets the effect of public inpatient capacity on suicide rates. Unfortunately, macro-level data do not allow estimates of the proportion of jail and prison inmates with mental illness. One study, comparing two jails in different catchment areas, one with higher levels of community-based mental health services found no difference in the prevalence of mental illness across the two jails (Fisher, Packer, Simón, & Smith, 2000). Together, although limited in scope, the findings from these studies suggest that provision of greater community-based mental health services alone may not be sufficient to reduce the number of persons with mental illness in jail.

3. Public perceptions of dangerousness associated with mental illness

3.1. The changing nature of public understanding of mental illness

There is both ‘good news’ and ‘bad news’ when it comes to public understanding of mental illness generally. Early research in the 1950s, based on a nationally representative survey, asked respondents the open-ended question: When you hear someone say that a person is ‘mentally ill,’ what does that mean to you? Results showed that Americans had a somewhat narrow view of mental illness, with the majority associating mental illness with psychosis. For example, respondents indicated that mental illness means that “persons are not in touch with reality” or “live in their own world.” Respondents also used colloquial terms such as “nuts,” “deranged,” or “out of one’s mind” to describe mental illness (Starr, 1955). In 1996, the same question was asked again in a nationally representative survey. This time, fewer persons gave answers reflecting psychosis (35%) and more persons gave responses reflecting other disorders such as anxiety/depression (34%), personality disorders, substance abuse, or cognitive impairment, suggesting that the public’s conceptions of mental illness has broadened beyond stereotypical conceptions associated with psychotic disorders and is seen as something less alien and extreme (Phelan, Link, Steuev, & Pescosolido, 2000).

Recent research used vignettes that described persons who fit the criteria for one of several mental illnesses (schizophrenia, major depression, and substance dependence) and asked respondents whether they thought “the person was likely to have mental illness?” About 88% said “yes” when presented with a description of a person with schizophrenia, and about 69% said “yes” when a person with major depression was described. When asked specifically whether they thought the person was “likely to have depression,” 95% said “yes” (Link, Monahan, Steveuw, & Cullen, 1999; Link, Phelan, Bresannah,
Stueve, & Pescosolido, 1999). Also, Americans are more likely to attribute the causes of disorders such as schizophrenia and depression to chemical imbalances, genetic factors, and stressful life circumstances, rather than to “bad character,” “the way the person was raised,” or “God’s will” (Martin, Pescosolido, & Tuch, 2000). Together, these findings suggest that public understanding of the causes of mental illness has become somewhat more sophisticated and consistent with professionals’ views.

3.2. Perceptions of dangerousness

However, the ‘bad news,’ concurrent with these favorable developments, is that there has been an increase in the proportion of persons who associate mental illness with dangerousness, violence, and unpredictability. In 1950, when asked what ‘mental illness’ means to them, about 7% of respondents mentioned violent manifestations or symptoms, compared to 12% in 1996. Also, those who think of mental illness in terms of psychosis are more likely to associate mentally ill persons with dangerousness and are less willing to live near them, socialize with them, work with them, have a group home for the mentally ill nearby, or have someone with mental illness marry into their family, i.e., they want to have greater ‘social distance.’ Moreover, perceptions of dangerousness increase support for coercive measures to treat persons with mental illness, such as involuntary commitment (Pescosolido, Monahan, Link, Stueve, & Kikuzawa, 1999).

Paradoxically, public understanding of mental illness has apparently increased, yet perceptions of persons with psychotic disorders as dangerous have increased as well. A likely possible explanation is that media images and high publicity surrounding certain violent events have created misunderstanding of the actual risk of violence. While there has been a good deal of research on how mental illness is presented in the mass media, in terms of inaccurate depictions and overemphasis on violence (Corrigan, 2005; Wahl, 1995), the link between media portrayals and attitudes toward mental illness has not been fully examined. However, one study found that highly publicized college campus shootings may lead to increases in fear among college students of being a victim of violent crime on campus (Kaminski, Koons-Witt, Thompson, & Weiss, 2010).

3.3. Causal attributions

Recent research has examined the effects of beliefs about the causes of mental illness and perceptions of dangerousness on attitudes toward persons with mental illness. Survey studies using experimental vignettes examined the impact of causal attributions and perceptions of dangerousness on responses toward persons with mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003). This research has shown that when the onset of mental illness is viewed as being under one’s control (e.g., as a result of drug use), persons are more likely to avoid, withhold help, and endorse coercive treatment. Also, when persons are seen as responsible for causing their condition, this leads to decreased feelings of pity and increased feelings of anger and fear. Anger, fear, and lack of pity, in turn, lead to rejecting responses, such as social avoidance and increased support for the use of coercive control. The findings also show that information about dangerousness increases the likelihood of discriminatory responses. However, findings from this study also suggested that those who are more familiar with mental illness are more likely to offer interpersonal help and less likely to avoid people with psychiatric disorders (Corrigan et al., 2003). Taken together, this research suggests that certain beliefs about mental illness may increase discrimination toward persons with mental illness, resulting in social exclusion, and further limiting employment and housing opportunities, all of which may then worsen psychiatric condition and may thus exacerbate the likelihood of aggressive behavior.

In an innovative study among police officers in a major metropolitan area, Watson, Corrigan, and Ottati (2004) showed that when suspects are described as having schizophrenia, they are viewed not only as less responsible for their condition and more in need of help but also as potentially more dangerous. This highlights the paradoxes inherent in attitudes toward persons with mental illness—on one hand, increased understanding of mental illness and its causes, yet increased fear and stigma on the other. A limitation of the study was that it did not indicate the type of behavior the suspect was exhibiting. Also, given the lack of real-life context in these types of studies, it may be difficult to evaluate to what extent educating police officers and others on mental illness and diagnostic labels would help them manage situations in such a way that minimizes escalation of conflict, leading to violence.

4. Individual-level research on mental illness and the likelihood of violence and crime

4.1. Treatment sample studies

Given public perceptions and conflicting interests among advocacy groups, the risk of violence among persons with mental illness has been a somewhat ideologically charged issue, with some emphasizing increased risk as a way of highlighting the need for better and more compulsory treatment, and others downplaying the risk of violence as a way of reducing stigma and discrimination that may worsen a person’s psychiatric condition (Monahan, 1992; Torrey, Stanley, Monahan, & Steadman, 2008). Much research has examined the direct relationship between mental disorder and the likelihood of violent and criminal behavior. One major study—the MacArthur Violence Risk Assessment Study—compared the frequency of violence among patients discharged from inpatient treatment units with that of a “matched” sample of persons living in the same (often disadvantaged) neighborhoods (Monahan et al., 2001). The study found a higher risk of violence among persons with mental illness that had co-occurring substance abuse disorders. This suggested that mental illness affects violence indirectly by increasing the likelihood of substance abuse. The most recent and comprehensive study, including over 1400 adult patients with schizophrenia sampled from 57 clinical sites in 24 states showed that about 19% reported violent behavior in the last 6 months, a rate much greater than would be expected in the general population (Swanson et al., 2006).

One of the limitations of studying persons who are in treatment is that they may be ‘selected’ into treatment because they are inclined toward disruptive behavior, thus producing somewhat of an upward bias in the prevalence of violence among persons with, for example, conditions such as schizophrenia or bipolar disorder. However, persons with these types of disorders are the most likely among those with mental illness to receive specialty treatment at some point in the lifetimes (Wang, Demler, & Kessler, 2002). On the other hand, as in the MacArthur study, persons with schizophrenia with low insight and paranoid symptoms are significantly less likely to take part in studies, and may thus contribute to an underestimate of the risk of violence (Torrey et al., 2008). It is not clear exactly to what extent these types of countervailing biases affect estimates of the likelihood of violence among persons with mental illness.

4.2. Community sample studies

One influential study that used data from the New York metropolitan area included those in treatment and a community sample and asked about self-reported violent behavior and arrests. This study also included data on respondents’ official arrest records (Link, Andrews, & Cullen, 1992). It showed that those who were either new, ongoing, or former patients, including many with schizophrenia, bipolar disorder, and major depression are at an increased risk of
violence and arrest compared to those with no treatment history (Link et al., 1992). In this case, while estimates of arrests are more objective, there is still the problem of the validity of self-reported aggressive behavior. However, in general, studies have shown that self-reports are valid, but that there may be a tendency for racial minorities to underreport violent behavior (Hindelang, Hirschi, & Weis, 1981). In an effort to overcome this, Link et al. (1992) employed controls for social desirability bias to correct for underreporting, along with controls for demographic variables, including race. An important limitation to this study is that a significant portion of those with mental illness go untreated; therefore, treatment history itself is an imperfect indicator of mental health status (Kessler et al., 2005).

The best, larger scale studies use diagnostic criteria to establish the prevalence of mental illness, irrespective of treatment history and also include self-reported measures of violence. They yield similar findings to the studies above. Using data from the Epidemiological Catchment Area (ECA) study, Swanson, Holzer, Ganju, & Jono (1990) found that violent behavior, including hitting, throwing things, and use of weapons in the last year was found among 25% of those who met the DSM criteria for a mental disorder, compared to only 2% of those with no mental disorder. Studies using data from Israel and Finland with comparable measures, yielded similar results (Link, Monahan, et al., 1999; Link, Phelan, et al., 1999; Tiilinen, Isohanii, Rasanel, Koiranen, & Moring, 2007).

It is important to note, however, that persons with mental illness are not only more likely to engage in violent behavior, but controlling for their own violent behavior, are also more likely to be the victims of violence (Choe et al., 2008; Silver, Arseneault, Langley, Caspi, & Moffitt, 2005; Teplin et al., 2005). This is understandable, given that violent encounters are most often a two-way street—one person initiates violence while the other engages in violence as a means of responding to threats or in retaliation for perceived harm (Tedeschi & Felson, 1994). Furthermore, people with severe mental illnesses such as schizophrenia, bipolar disorder, or major depression are at increased risk of death by not only suicide but also homicide (Hiroeh, Appleby, Mortensen, & Dunn, 2001).

4.3. Symptoms associated with violence

Both the treatment sample and general population studies show that, in many cases, those experiencing certain “positive” psychotic or “threat control/override” symptoms (e.g., delusional thinking and hallucinations) are at an increased risk of violence (Elbogen & Johnson, 2009; Swanson, 1994; Link, Monahan, et al., 1999; Link, Phelan, et al., 1999; Swanson et al., 1996; Swanson et al., 2006; Teasdale, 2009). Consistent with symbolic interactionist theory, persons experiencing these symptoms may accept irrational thoughts as real, misperceiving the actions of others (including family members or police officers) as threatening and respond aggressively (Link, Monahan, et al., 1999; Link, Phelan, et al., 1999). In contrast, patients with “negative” symptoms (e.g., social withdrawal) are at a lower risk of violence. Moreover, one study finds the effect of threat-control override symptoms is limited to men (Teasdale, Silver, & Monahan, 2006). These studies also show that the risk of violence is increased among those with multiple disorders, those with co-occurring substance use/dependence disorders, and noncompliance with medication regimens that reduce troublesome symptoms (Swartz et al., 1998).

Despite emphasis on symptoms, other problems associated with mental illness must be taken into account. Matejkowski, Solomon, & Cullen (2008) found that, among 95 persons with severe mental illness who were convicted of murder in Indiana between 1990 and 2002, most were raised in households with significant family dysfunction, had extensive histories of substance abuse and criminality, and had received little treatment for their mental and substance use disorders. Furthermore, some nonviolent criminal behavior among homeless persons with mental illness may be considered “survival” crimes, such as shoplifting and trespassing. Also, some crime may result from “antisocial” personalities that are a part of some mental illnesses (Hiday, 1997).

4.4. Demographic factors

Very importantly, in the community studies discussed above, the association between mental disorder and violence or arrest holds after controlling for demographic factors. In fact, the risk of violence among those with mental illness is at par with or exceeded by the risk associated with simply being male, younger, or a disadvantaged racial minority. In terms of public perceptions, demographic variables, while perhaps contributing to fear of crime (Quillian & Pager, 2001), are likely seen as unchangeable, while mental illness may be regarded, to a certain extent, as something the person “brought on themselves,” thus outweighing demographic variables that compound perceived risk. Therefore, persons may be more likely to discriminate based on the knowledge that someone has mental illness, for fear of disturbing behavior, than based on demographic characteristics, that, when taken together, determine the risk of violence to a greater extent. The interaction among demographic variables and mental illness in their impact on risk and perceptions of dangerousness remains to be fully examined.

5. Community context: The role of socially disorganized neighborhoods in violence among persons with mental illness

5.1. Social disorganization and mental illness

Theories that explain crime generally can be applied to understand crime and violence among persons with mental illness. Key to this approach is understanding how mental illness enhances the effects of crime-causing variables. One important explanation is that seriously mentally ill persons have long been more likely to reside in disadvantaged urban areas, as a result of the downward drift in socioeconomic status that mental illness often leads to (Faris & Dunham, 1939). Currently, as a result of deinstitutionalization, lack of long-term care facilities, and selection processes that limit job and residential opportunities, many mentally ill and homeless persons reside in group homes, shelters, or single-room occupancy hotels, or in subsidized housing, all of which are more likely to be located in “socially disorganized” neighborhoods. These are neighborhoods where there are more economically disadvantaged persons, there is greater racial diversity, and there are more fragmented families. Social disorganization theory predicts that neighborhood disorganization leads to weakened social cohesion, thereby lessening the ability of communities to exert both formal and informal control over the behavior of their residents, resulting in increased crime (Bursik & Grasmick, 1993; Markowitz et al., 2001; Sampson & Groves, 1989; Sampson et al., 1997). Moreover, in these types of neighborhoods, cultural norms regarding violent retaliation in disputes are prevalent (Anderson, 2000). Following from this line of thinking, studies show that, for persons with mental illness, living in such neighborhoods increases the risk of criminal offending beyond individual demographic characteristics, highlighting the role of criminogenic contexts in facilitating violence (Silver, 2000a;b, Silver, Mulvey, & Monahan, 1999).

5.2. Police encounters

In the face of limited treatment options, disturbing behavior that might have been dealt with medically prior to deinstitutionalization is now more likely to be treated as criminal behavior. For example, even though police may recognize some disruptive behavior as resulting...
from mental illness, they often have little choice but to use “mercy bookings” as a way to get persons into mental health treatment. Police officers are among those most likely to deal with persons with mental illness in crisis situations and are now one of the main sources of referral of persons into mental health treatment (Engel & Silver, 2001; Lamb, Weinberger, & DeCuir, 2002). Also, police, who see troublesome situations through the lens of their role as “law enforcers” are motivated to maintain their authority in conflict situations, often invoking the power of arrest to do so (Watson & Angell, 2007).

In the wake of deinstitutionalization, these processes have led some to argue that mental illness has been “criminalized” (Lamb & Weinberger, 1998; Lamb et al., 2002; Steury, 1991; Teplin, 1990). The evidence in support of the criminalization hypothesis comes primarily from the systematic observation of police–citizen encounters that show mentally ill suspects are more likely to be arrested than their nonmentally ill counterparts (Teplin, 1984). However, a more recent study of police–citizen encounters in 24 police departments in three metropolitan areas elaborates on those findings (Engel & Silver, 2001). That study showed that other factors, not considered in previous research, such as whether suspects are under the influence of drugs, are noncompliant, fight with officers or others, as well as the seriousness of their offense predicts the likelihood of arrest among mentally ill suspects. Consistent with that research, Kaminski (2007), using pooled time series data of the 50 states for the period 1972 to 1996 found that the number of mentally ill persons released each year from state and county mental hospitals was related to rates of lethal violence against the police. An important implication of these studies is that if mentally ill persons are overrepresented in criminal justice settings, it is not solely attributable to discriminatory treatment on the part of police, but due, in part, to a greater likelihood of arrest-generating behavior. Many cities have attempted to mitigate the potential for conflict in police encounters with mentally ill citizens by implementing crisis-intervention training (CIT) programs. However, it is difficult to fully assess their effectiveness. Some studies indicate that while CIT improves police understanding of mental illness, it may not reduce, for example, the use of force and the likelihood of arrest (Compton, Bahora, Watson, & Oliva, 2008). Factors, such as the availability of nonjail treatment, may offset effects of CIT.

6. Situational dynamics: The role of stress and conflicted relationships in violence among persons with mental illness

6.1. Stress and conflicted relationships

Research on the role of stress and mental illness has been brought to bear on understanding part of the reason that persons with mental illness are at an increased risk of violent behavior and victimization. This research is guided by the logic of the stress process model, the dominant approach to understanding the social patterns of psychological distress—more common, sub-clinical symptoms of anxiety and depression (Mirowsky & Ross, 2003). The theory holds that stress (or life strains) places persons at risk of psychiatric illness and that stress is socially distributed, principally according to socioeconomic status, gender, age, and marital status. Moreover, social support and other coping resources (e.g., self-efficacy) mitigate the effects of stress on well-being. Hiday (1995) was among the first to develop a model that applies these insights to violence and serious mental illness. In her model, economic disadvantage not only places persons at risk for developing symptoms of mental illness, but also because of the disadvantage that mental illness creates, persons with mental illness experience greater levels of stress and conflict. Aggressive behavior becomes both an externalized expression of symptoms and a way of coping with conflict, fear, and goal-blockage—especially in socially disorganized neighborhoods where violence is more common. The findings of several studies are consistent with the stress model. Using ECA data, Silver and Teasdale (2005) find that, controlling for social demographic variables, stressful life events (e.g., disruptions or changes in employment, relationships, and living situations) in the past year and impaired social support explained a significant portion of the association between mental/substance disorders and violence. Although untested, it is likely that disputes with intimates surrounding involuntary treatment, efforts to control disruptive behavior, and financial disagreements may facilitate violent behavior (Estroff et al., 1994). In fact, similar to violence committed by nomen tally ill persons, family members are highly likely to be the targets of violence involving persons with mental illness (Estroff et al., 1994).

Similarly, DeCoster and Heimer (2001) find that violent behavior is a response to stressful life events and an externalized expression of depressive symptoms among young adults. Since stressful life events are structured by social background factors, notably social class, these types of studies link criminological and mental health research by suggesting an important pathway by which disadvantaged persons become involved in serious violence. Moreover, depressive symptoms weaken family attachments, which, in turn, can lead to further depression and aggressive behavior (DeCoster & Heimer, 2001). This is consistent with research that shows that not only are social relationships important for reducing symptoms, but that, unfortunately, symptoms may erode the quality of social relationships (Markowitz, 2001). One way this operates is through aggressive behavior.

7. Public policy responses

7.1. Community treatment alternatives

In recognition of the risk of violence and criminalization of mental illness, there have been increased efforts to provide services within correctional settings and support for community treatment alternatives, such as intensive case management, jail diversion programs, including mental health courts, and legally mandated assisted outpatient treatment (Compton et al., 2008; Dvoskin, 1994; Morris et al., 1997; Morris et al., 1999; Steadman et al., 1995, 1999; Watson, Hanrahan, Luchins, & Lurigio, 2001). These types of programs take a variety of forms: some with mental health professionals involved at the scene of a disturbance and diversion taking place prior to arrest, others with diversion taking place after arrest (involving special mental health courts), or crisis intervention training for police to manage persons in crisis situations and help them get into treatment facilities, rather than into jail (Reuland & Cheney, 2005). Such programs require effective coordination between law enforcement, judges, prosecutors, and mental health professionals. However, the cultural orientations of these groups can be at odds—public order, authority maintenance, and punishment versus treatment. The evidence regarding the effectiveness of these often uncoordinated programs is somewhat limited in terms of symptom improvement, quality of life, and likelihood of re-offending, according to the findings of a large (n = 2000), national, randomized, multi-site study (Broner, Lattimore, Cowell, & Schlenger, 2004; Fisher, 2003; Mechanic, 2008). However, one recent study using random assignment of subjects to a post-booking jail diversion program found that those in the program experienced reduced contact with the criminal justice system over a 12-month evaluative period (Case, Steadman, Dupuis, & Morris, 2009). Reductions were greatest among those with a criminal history. However, no improvements were shown regarding symptoms, suggesting that these types of programs may have more a public safety, rather than public health benefit.

7.2. Outpatient civil commitment

The majority of states’ laws allow for mandatory assisted outpatient treatment (outpatient civil commitment, or AOT) for those who lack the capacity to care for themselves, many of whom are at risk of homelessness and criminal behavior (Appelbaum, 2005).
However, relatively few states implement the law or have a comprehensive system of treatment programs to accompany it. There have been some attempts to gauge the effectiveness of AOT. One study of 78 patients in New York City did not show any differences in outcomes between those who received court-ordered mental health services and those who received non-court-ordered services (Steadman, 2001). However, that study excluded persons with a history of violence. Another study of several thousand patients throughout New York State that had been considered for court-ordered treatment as a result of troublesome behavior reported significant improvements in service use and community living among those under an AOT order compared to those not under such an order (Van Dorn et al., 2010). However, patients were not randomly assigned to AOT. Moreover, one implication of these studies is that it may simply be the availability of services, rather than the court-order per se that led to improved outcomes.

Unless implemented on a significant scale, these types of programs may be insufficient to take the place of public institutions focusing specifically on the inpatient care of persons with serious mental illness and substance abuse disorders. Moreover, these types of programs are likely to be most effective when they address a wide set of issues that are required to facilitate recovery from mental illness more generally, including illness management, employment, housing, substance abuse, and trauma intervention (Osher & Steadman, 2007; Watson et al., 2001). This has led Fisher, Roy-Bujnowski, et al. (2006) and Fisher, Silver, and Wolff (2006) to argue there has been an overemphasis on “need for services” in reducing violence among mentally ill persons rather than on the more general factors that lead to criminal behavior, such as the failure to make normative life course transitions, economic disadvantage, and criminogenic lifestyles that can accompany mental illness.

8. Conclusion

In sum, public psychiatric hospital capacity is an important source of control of those whose behavior or public presence may at times threaten the social order. This capacity has been reduced dramatically over the last several decades. In the absence of this capacity, many persons with mental illness have fallen through the cracks of community based services, which can be effective, but are often fragmented and require active engagement on the part of persons who require them, yet may not recognize the need to do so. Unfortunately, this leads to an increased risk of homelessness and involvement in the criminal justice system, as well as victimization. The problem is especially pronounced among those who are economically disadvantaged, who are more likely to reside in “disorganized” neighborhoods, where stress and cultural differences in dispute resolution enhance the risk of crime.

Concurrently, public perception of violence among persons with mental illness has increased over the last several decades. Despite an apparent improvement in understanding the nature and causes of mental illness, there is the tendency to associate mental disorders, especially psychosis, with an increased likelihood of violence. As such, the general public’s perceptions are not entirely out of line with objective assessments of risk. Unfortunately, perceptions of violence are a significant component to the stigma associated with mental illness which likely adds to the devaluation and discrimination that many persons who are diagnosed—yet are not violent—experience. Stigma and social rejection, in turn, limits social opportunities, such as jobs, housing, and social networks for persons with mental illness, which, to some extent, serve as protective factors in reducing stress, and thereby reducing the risk of violence.

The proportion of persons with mental illness who are at risk of violence or other criminal behavior is modest. In the aggregate, the risk translates into appreciable increases in the rates of violent and other types of crime, resulting in substantially greater numbers of persons with mental illness who find their way into the criminal justice system—a system that was not intended for therapeutic purposes, but has been forced to adapt by becoming the nations largest residential facility for the mentally ill. High quality, well-coordinated community mental health services that focus on both symptom reduction and social-economic well-being (e.g., housing and employment) may reduce the number of mentally ill persons who end up in jails and prisons. In response to this significant social problem, congress has enacted the Mentally Ill Offender Treatment and Crime Reduction Reauthorization and Improvement Act of 2008, intended to provide more funding for local programs that will help divert persons from the criminal justice system into mental health treatment. Such efforts require tremendous initiative on the part of policy makers and local agencies, and are likely to be limited in their development and effectiveness relative to the scale of the problem. An important next step for research is to compile systematic data at the community level on such services in order to assess their aggregate impact. Also, national jail survey data needs to make offenders’ city-level identifiers available to researchers so that aggregate estimates of the proportion of persons with mental illness in jails in a given city can be computed and linked with data on mental health services and examined across a number of cities.

References

Arvanites, T. M. (1988). The impact of state mental hospital deinstitutionalization on community based services, which can be effective, but are often