Local Variations in Arrests of Psychiatric Patients

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The involvement of psychiatric patients in the criminal justice system has come under increasing attention in the psychiatric literature within the past five years. Research conducted by Zitrin et al,[1] Durbin et al[2] and Sosowsky[3] demonstrated that mental patients are arrested more frequently than non-mentally ill persons in three distinctly different regions of the United States. That mentally ill persons, or at least certain groups of mentally ill individuals, are arrested more frequently than the average person seems now to be accepted. More recent research, conducted by Steadman et al,[4] is aimed at explaining these apparently high arrest rates.

Steadman found three factors which contributed to increased arrest rates: history of prior arrest, age and hospital admission diagnosis. Those patients with arrest records were younger than patients with no arrest experience. The patients with admitting diagnoses of substance abuse or personality disorders were arrested significantly more often than those patients with other admitting disorders including psychosis. In relation to arrest history, Steadman found that patients with prior arrests were more likely than other patients to be arrested again. In a second study, Steadman[5] compared arrest rates of mental patients with those of criminal offenders. He found that mental patients with no arrest history prior to psychiatric hospitalization had a subsequent arrest pattern no different from the general population; however, with multiple arrests before psychiatric hospitalization the subsequent arrest rates of these patients is indistinguishable from criminal recidivists. Steadman demonstrates that there are sub-groups of mentally ill persons who are arrested on multiple occasions and that these patients, when lumped with other hospitalized patients, distort arrest rates for the larger group.

He concludes: "The issue is not so much that there are more mentally ill people at risk for criminal activity in the community; more accurately, the problem seems to be that there are more criminals in mental hospitals in the first place."[6]

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Guze,[7] commenting on Steadman's research, emphasizes the need for a study which looks carefully at psychiatric diagnosis and criminal history. Zitrin[7] felt that relationship of schizophrenia to serious crime "Remains in dispute." The data presented by Zitrin clearly points out potential for violent crime associated with a sub-group of schizophrenics. This group also had the highest mean number of arrests. The question of diagnosis is a serious question. It is not proper to dismiss the multiple arrest group as simply "criminal." The relationship of arrest rates and serious mental disorder must be investigated further in order to define diagnostic subtypes. Beyond diagnosis, there are systems issues which relate to the changes in civil commitment statutes, the concept of criminalization of the mentally ill and treatment issues in community care. All of these areas involve major public policy problems which may interact to influence arrest rates.

The research reported in this paper is an extension of a study reported by Shore et al[8] which evaluated the outcome of 189 involuntary patients entering the Oregon civil commitment process. These 189 patients entered the pre-commitment process through the in-patient psychiatric service of the University of Oregon Medical School. The study reported that the 189 patients demonstrated on initial evaluation a significant degree of psychopathology. When compared to a group of 2,000 inpatients from New York State, the Oregon group showed severity of clinical symptoms above the 80th percentile on an 18-item clinical symptom scale. Over 50% of all patients in the study were diagnosed as suffering from psychosis, predominantly schizophrenia. The study reported a high degree of both mortality and morbidity in the study group on follow-up. Contact with outpatient care was correlated positively with improvement regardless of commitment status.

This current study was designed to examine the relationship between the mental health and criminal justice systems by examining the arrest records of the 189 patients. We were interested in exploring: 1) relationship between arrest records and psychiatric diagnosis; 2) the occurrence of criminalization of the mentally ill in Portland, OR; 3) comparison arrest rates among different psychiatric populations, voluntary and involuntary psychiatric in-patients and 4) an attempt to verify findings in the psychiatric literature as described above.

Method

The original study group consisted of all patients (n=189) who entered the commitment process through the University of Oregon Psychiatric Crisis Unit from January through June, 1976. For the purposes of the current study, all voluntary patients (n=95) admitted to the same in-patient service during the same six-month period were identified as a comparison group. For this comparison group, it was not possible to apply prospective diagnostic criteria originally developed in the first study. For the 95 patients

in the comparison group, charts were reviewed to obtain comparative demographic and diagnostic data.

For each patient in both the study (n=189) and the control (n=95) groups, arrest records were reviewed. This was accomplished by review of records maintained by law enforcement agencies in the Portland metropolitan area. This review took place in December, 1978. If an individual were arrested within four years prior to the 1978 date, the law enforcement records would document all previous arrests. If no arrest took place during the four-year period, these individuals would not have an active law enforcement file. Arrests which took place outside of the Oregon jurisdiction would not necessarily be included in the available data. It therefore follows that this research would not provide complete data on all arrests of the individuals reviewed and the findings would be limited in underpredicting rather than overpredicting arrest records. Because of these limitations in the data available, we did not attempt to construct arrest rates for the groups in question, nor to make an attempt to correlate our data with arrest rates for the metropolitan or state populations.

Results

In the original research protocol (n=189) patients were asked about previous arrests as part of the intake history; 42 (22%) of the patients gave a positive history of criminal arrest. This represents only about one third of those with verifiable arrest records. Table 1 compares the involuntary group versus the voluntary groups in relation to arrest records obtained from the law enforcement agencies; 112 patients (59%) of the involuntary group had arrest records while 43 (45%) of the control group had a history of prior arrests. The study group had a significantly higher arrest record than did the control group. Table 2 examines the distribution of psychotic and non-psychotic individuals compared with history of arrests for the involuntary group. Within the involuntary group, there is a significantly greater percentage of psychotic individuals with arrest histories. This finding does not extend to the voluntary group where psychotic individuals are not more likely to be found to have had involvement in the criminal justice system.

The two groups had the following demographic characteristics. The involuntary group with a history of arrests (n=112) consisted of 81 (72%) men and 31 (28%) women; 95 patients (85%) were caucasian, 16 (14%) were black and one (1%) was of Mexican background. The mean age of the men was 31.4, while the mean age of the women was 32.8. The mean age of those

Table 1: Comparison of Arrest Records for Involuntary and Voluntary In-Patients:*

	Involuntary Group (N=189)	Voluntary Group (N=95)
History of arrests	112 (59%)	43 (45%)
No history of arrests	77 (41%)	54 (55%)

*Significant ($P < .05$) (Chi-square = 4.44)

involuntary patients who were not involved in the criminal justice system was 35.8 for men and 40.4 for the women. For those patients from the voluntary group with arrest records (n=43), there were 22 (51%) men and 21 (49%) women. In this group there were 36 (84%) caucasians, five (11%) blacks and two (5%) Mexican Americans. The mean age for the males was 32.9 and 31.1 for the women. In this group, the mean age of the voluntary patients not involved in the criminal justice system was 33.1 for the men and 31.8 for the women, similar to patients with arrest records. It is not possible to comment on other demographic variables as the voluntary group was studied retrospectively.

Table 3 presents diagnoses of both the involuntary and voluntary groups who have arrest records. For the involuntary group, the modal diagnostic category is schizophrenia, with 49 (44%) of the patients suffering from this disorder. The second leading diagnostic group is personality disorder, with 29 (26%) of the patients in this category. For the voluntary group, the leading diagnostic categories are reversed, with 17 (39%) of the patients diagnosed as personality disordered and eight (19%) diagnosed as schizophrenic.

Table 4 compares schizophrenia versus all other diagnostic categories for both the involuntary and voluntary patients with arrest records. The difference between the groups is statistically significant and shows that schizophrenics are overrepresented in the involuntary group. In comparing persons with character disorders in both groups, the difference between voluntary and involuntary groups is not significant.

Table 5 compares the involuntary and voluntary groups in terms of numbers of arrests per patient. For both groups, a single arrest was most frequent, with 35 (31%) of the involuntary and 19 (44%) of the voluntary group having one arrest. In the involuntary group, there is one patient who

Table 2: Comparison Arrest Records and Psychosis: Involuntary Group* (N=189)

	Arrest History (N=112)	No History of Arrest (N=77)
Psychotic	65 (58%)	29 (38%)
Non-psychotic	47 (42%)	48 (62%)

*Significant ($p < .01$) (Chi-square = 7.10)

Table 3: Diagnosis (Patients with arrest record)

	Involuntary (N=112)	Voluntary (N=43)
Schizophrenia	49 (44%)	8 (19%)
Manic Depressive	13 (11%)	7 (16%)
Acute Psychosis (other)	3 (3%)	2 (5%)
Neurosis	14 (12%)	7 (16%)
Personality Disorder	29 (26%)	17 (39%)
Organic Brain Syndrome	2 (2%)	—
Adjustment Reaction Adolescent	2 (2%)	2 (5%)

has had 27 different arrests, while in the voluntary group the largest number of arrests is eight. The involuntary group had a total of 341 arrests with 150 (44%) in the felony range and 191 (56%) in the misdemeanor category. The involuntary group had an average arrest per patient of 3.04. The voluntary group had a total of 121 arrests, of which 43 (36%) were for felonies and 78 (64%) were for misdemeanors. The average arrest per patient in this group was 2.81. The involuntary schizophrenic patients (n=49) accounted for 135 total arrests, of which 59 (44%) were felonies and 76 (56%) were for misdemeanors. The average number of arrests for schizophrenic patients in this group was 2.75 per patient. If the patients who were arrested for a single crime are subtracted from each group, the involuntary patients had an average of 3.97 arrests per patient, while the voluntary group had an average of 4.2 arrests per patient. The involuntary schizophrenic group had an average of 3.86 crimes per patient.

Discussion

This study compares arrest records of a group of involuntary and voluntary patients admitted to a short-term psychiatric unit in a metropolitan center. The involuntary patients were all in the pre-commitment phase of the Oregon civil commitment process and were admitted predominantly on a petition initiated by local police and secondarily on a physician's petition signed in the psychiatric emergency room. The control patients came through the same emergency room and tended to be family or self-referred. These patients agreed to enter the hospital on a voluntary basis. It is likely that some were given the "choice" in the emergency room of either signing a voluntary admission or having the physician's petition for involuntary admission. The initial study reported by Shore et al focused on outcome measures for the involuntary patients in relation to the civil commitment proceedings and the patient's psychiatric status on follow-up. The present study examined arrest records of this group and compared these records to

Table 4: Comparison of Schizophrenics (with arrest records) versus all other diagnostic categories*

	Involuntary (N=112)	Voluntary (N=43)
Schizophrenic	49 (44%)	8 (19%)
Not schizophrenic	63 (56%)	35 (81%)

*Significant ($p < .01$) (Chi-square = 8.8)

Table 5: Number of arrest/patient, comparison of patient groups

Number of arrests	Involuntary (N=112)	Voluntary (N=43)
1	35 (31%)	19 (44%)
2	28 (25%)	7 (16%)
3	24 (22%)	2 (5%)
4	7 (6%)	8 (19%)
5 +	18 (16%)	7 (16%)

the arrests of voluntary patients admitted to the same in-patient service during the same time. The involuntary patients are significantly different from the voluntary patient group in that they had a higher proportion of arrests, and they contained more patients with diagnoses of psychosis and in particular more schizophrenic patients. Both groups contained a large number of individuals with diagnoses of character disorders and were not significantly different in this regard. Those arrested in the involuntary group were younger than the involuntary patients who were not arrested. This same trend does not hold in the voluntary patient group.

Oregon's civil commitment law is a restrictive statute[9-10] and especially as it is interpreted in the metropolitan area, it is difficult to have a person civilly committed. The current statute was enacted into law in 1974. Although we do not have comparative data prior to 1974, the current data indicates that mentally ill patients, especially some schizophrenic patients, have an impressive number of detentions in the criminal justice system and, in that sense, these patients may be "criminalized." The supporting data comes from the significantly higher proportion of schizophrenic patients in the involuntary group in this study who have previous arrest history; however, a definitive statement in this area awaits a prospective study which would follow first break schizophrenic patients over a long period through the various systems, examine each instance of hospitalization or arrest, and evaluate the "symptomatic" behavior associated with each detention.

In the context of the growing literature on mentally ill patients and criminal arrests, this study may demonstrate a regional specificity of the findings. Portland is a city with a large number of deinstitutionalized chronic schizophrenic patients living in marginal circumstances. There are inadequate community mental health services and a highly restrictive civil commitment law. The local Portland civil commitment court is the most adversarial probate court in the state, operating with a stringent interpretation of dangerousness to self and others. In this environment, diversion to the criminal justice system as an unplanned consequence of civil commitment reform is likely, and, in our opinion, definitely occurs. Social dynamics similar to those described above were recently described by Bonovitz and Guy[11] in a report describing the impact of civil commitment procedures on a county jail psychiatric ward in Philadelphia. Local and state social policy matters are postulated as an extremely important element in whether a schizophrenic patient ends up in jail or in the hospital. For example, a recent Portland controversy between the mental health authority and the police over patient transport may increase arrests of mentally ill patients.

When this study and the recent literature is viewed from a national perspective, there is agreement with Steadman's findings. Diagnoses of character disorder, younger age and previous arrests make up the base of the phenomena we are now viewing. This accounts for the high numbers of such patients in both of our study groups; however, our data does not

support a simple hypothesis that more criminals are now in mental hospitals. The original 189 patients in our involuntary group showed severe psychopathology compared to New York State inpatients. This included many patients with diagnosis of schizophrenia. Because of design limitations of our study in diagnostic reliability, we are not able to answer conclusively Guze's question cited earlier in this paper regarding psychiatric diagnosis and criminality. Prospective studies which apply research diagnostic criteria to patients with arrest records are needed. With a research diagnostic approach, new clusters of patients may emerge that combine features of mental illness and antisocial behaviors.

As the relationship between arrest records and mental illness is scrutinized, many processes are occurring that reflect multiple changes in the definition of mental illness and in the care and treatment of individual patients. For those patients with arrest records, significant sub-groups can be identified. It is in this area of delineation of sub-groups that additional work is needed. Hopefully, this will lead to greater understanding of the effects of public policy changes on various groups of mental patients who have been and will be arrested. For those patients who have been criminalized by newly won constitutional safeguards, the costs must be analyzed and brought to bear on future public policy.

Acknowledgments

The authors wish to thank Stanley Cohen, PhD for his help in preparation of this report. The authors were supported in part by NIMH Psychiatry Education Grant #5 T01 MH 13462-06.

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