CASE REPORT

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Homelessness and the Mentally Ill Offender

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ABSTRACT: This paper presents the results of a retrospective analysis of the discharge summaries of 69 mentally ill offenders. The subjects were patients in a New York State Psychiatric Hospital for a two-year period between January 1988 and December 1989 who were referred by the courts under New York State Criminal Procedure Law (CPL). The subjects were further compared as to homelessness at the time of the instant offense to study the association of this variable and criminal behavior among the mentally ill. Statistical analyses demonstrated significant relationships between variables of homelessness, prior offense history, and substance abuse.

KEYWORDS: psychiatry, mental illness, prisons, homelessness, mentally ill offenders

The problem of homelessness in American cities has received national attention. New York City, with its large population and highly visible homeless population, has come to be a political battleground in addressing aspects of this societal problem.

Recently, an advertising executive was allegedly murdered by a homeless man in a quiet area of Greenwich Village. This murder, coupled with the increased aggressiveness of some homeless people when they panhandle and the commonly held belief that most homeless are mentally ill, has created concerns about the dangerousness of the homeless. Are the homeless mentally ill a threat to public safety? Researchers offer differing opinions on this question. According to Rabkin [*1*], Lunigo and Lewis [*2*], and Weller and Weller [*3*], studies looking at the association of mental illness and criminality prior to the mid-sixties revealed lower arrest rates for the mentally ill than for the general public. However, a number of other studies find increased criminal activity; Thornberry and Jacoby [*4*]; Klaasen and O'Conner [*5*]; Holcomb and Ahr [*6*]; Steadman and Felson [*7*]; and Zitrin et al. [*8*].

Deinstitutionalization, often cited as a contributing factor to increased numbers of homeless people on the streets of our cities, has also been linked to increased arrest rates

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among people with a history of mental illness [*9*]. It has been suggested [*10*] that the increase in arrest rate for the mentally ill may be a part of what Abramson [*11*] called the "criminalization hypothesis," which postulates that the mentally ill are not necessarily more dangerous, but are more likely to be arrested.

Most of what we know about the criminal behavior of the homeless mentally ill is descriptive and has been elucidated by studies of other issues [*12–16*]. Four recent studies look at the issue more closely:

- Belcher [*17*] in his study of 132 discharged mental patients found that those who became homeless were significantly more likely to be involved with the law. In his comparison of outcomes of different subgroups of patients discharged from a Middle Western state hospital for a six-month period, he links homelessness with increased criminal activity, but does not report on types of crime.
- Gelberg, Linn, and Leake [*18*] offer evidence that the homeless mentally ill may be at risk for violent criminal activity. They surveyed 529 homeless adults in Los Angeles for arrest and conviction rates and history of psychiatric illness. They found that homeless individuals with a history of psychiatric hospitalization are the ones most likely to have self-reported arrest and felony convictions from age 18. Gelberg et al. also describe an association between substance abuse, homelessness, and increased involvement in criminal activity. Of particular interest was their finding that previously hospitalized homeless subjects had more than twice the number of felony convictions as other homeless groups.
- Pruett [*19*] found that undomiciled male jail detainees in Chicago had the highest rates of serious mental disorders. The homeless subjects in her sample committed significantly greater numbers of violent crimes, which led her to conclude that a possible link between homelessness, mental illness and violent crime exists.
- Finally, Martell [*20*] in his survey of 137 offenders in New York City's primary forensic treatment facility found that 50% of the patients were undomiciled. While the homeless mentally ill in New York City represent only 2% of the mentally ill population of the city, he found a very significant association between homelessness and risk of forensic hospitalization. He also finds a significant association between indictment for violent crimes and homelessness.

These four studies, using a variety of methods and samples from various parts of the country, suggest that homelessness and substance abuse may be a risk factor for criminal behavior among the mentally ill. Three of the four (Pruett [*19*], Gelberg et al. [*18*], and Martell [*20*]) potentially support a link between homelessness among the mentally ill and violent crimes.

The purpose of this study was to examine which factors in a group of mentally ill offenders with predominantly nonviolent instant offenses were related to their domicility status. Our hypothesis was that there would be no differences in criminal and psychopathology measures between the mentally ill offenders who were undomiciled at the time of their instant offense and those who had a stable place to live.

Methods

We reviewed the discharge summaries of all the male patients released from a medium-security forensic service, the Special Services Unit (SSU), in a large urban state hospital for a two-year period between January 1988 and December 1989. Sixty-nine patients were released during the study period. The patients studied were mentally disordered offenders who were referred by the courts under New York State Criminal Procedure Law (CPL).

Patients were admitted to the SSU directly for treatment or were transferred there from a high-security hospital before release into the community. According to legal status there were four types of patients in the sample:

1. CPL Section 330.20 individuals found not responsible by reason of mental disease or defect—"not guilty by reason of insanity."
2. CPL Section 730.40 individuals who were found incompetent to stand trial, admitted for restoration to competency.
3. CPL Section 730.50 individuals who were declared permanently incompetent to stand trial.
4. Others—a small number who were admitted under civil commitment, including some patients dangerous to themselves or others, and who were incapable of being safely managed in a less secure facility.

This was a retrospective study. The information obtained for each patient was drawn from the inpatient charts and court records. Each patient had the following information coded from his records:

a. Demographic variables. These included age, race, and marital status. All subjects were male.

b. Diagnoses. These were obtained from the discharge summaries and hence reflected a diagnosis based on good knowledge of the subjects. *Diagnostic and Statistical Manual III-R* (DSM III-R) criteria were used. To make comparisons possible we clustered the patients into five diagnostic groups: schizophrenia alone, schizophrenia and substance abuse, mood disorders, organic mental syndromes, and substance abuse alone.

c. Psychiatric symptoms. The mental status examination at the time of admission to the forensic unit as well as hospital records were used to assess the presence of the following psychiatric symptoms: formal thought disorder, depression, delusions, paranoid behavior or content, manic behavior, and hallucinations. The symptoms were rated from 1 to 3 (1 = not present); their sum was calculated.

d. History of alcohol and drug abuse and being intoxicated at the time of the instant offense.

e. The charges were separated into the following six categories: violent (murder, manslaughter, assault, arson), nonviolent (robbery, burglary, harassment), property (vandalism, petty larceny), illicit substance (criminal possession or sale of controlled substance or paraphernalia), vagrancy (loitering), and other (fraud, telephone harassment).

f. Prior charges. This information was obtained from the RAP sheets contained in the court papers. Prior offenses were classified as violent and nonviolent using the same criteria as for the current charges.

g. Domicility. This pertained to where the subject was living at the time of the instant offense. Subjects were classified as homeless if they were living on the streets, shelters, or in public places such as bus stations or subways. Subjects classified as domiciled had either maintained a permanent address or were living with friends or family.

We compared mentally ill offenders who were domiciled at the time of the offense with those who were homeless at that time for their crime variables and level of psychopathology. We used two-tailed t-tests for the continuous variables and chi-square analyses for the dichotomous variables.

Results

Sixty-nine discharge summaries were reviewed. Sixty-five had adequate information and were included into the study. Among the subjects included, 40 were determined to be undomiciled and 25 were determined to be domiciled at the time of the instant offense.

Table 1 summarizes the demographic profiles of both the domiciled and undomiciled groups. The two groups were not statistically different in age, race, or legal status. All subjects were male. The diagnostic distribution of the two groups was significantly dif-

TABLE 1—*Demographic profile of subjects by homeless status.*

Parameter	Description	Homeless (n = 40)	Domiciled (n = 25)
Age	. . .	37.6 ±10.1	37.0 ±9.9
Race	Black	28	15
	Hispanic	4	5
	White	7	5
	Oriental	1	0
Legal status	N.G.R.I.[b]	2	2
	Eval. temporary	6	3
	Eval. final	32	18
	Other	0	1
Diagnoses[a]	Schizophrenia	10	12
	Schizophrenia and substance abuse	24	6
	Mood disorder	2	3
	Organic	4	3
	Substance abuse only	0	1
Charge	Violent	2	2
	Nonviolent	13	7
	Other	2	1
	Property	8	11
	Illicit substance	18	10
	Vagrancy	15	6

[a] $p < 0.05$.
[b] Not guilty by reason of insanity.

ferent ($x^2 = 5.25$, $df = 1$, $p = 0.02$). The homeless patients were more likely to have a dual diagnosis of schizophrenia and substance abuse (Table 1).

Subjects homeless at the time of their offense were significantly more likely to have a history of prior offenses than those nonhomeless at the time of their offense ($x^2 = 18.87$, $df = 3$, $p = 0.0003$). The majority of the undomiciled subjects who had a history of prior offenses had a history of mixed violent and non-violent offenses. If one dichotomizes subjects into those with offenses of any type and those without offenses, prior offenses distinguishes between the homeless and the domiciled subjects ($x^2 = 6.27$, $df = 1$, $p = 0.01$). Furthermore, when only violent prior offenses were taken into account, the homelessness status groups remained significantly different, the homeless group having more violent prior offenses than the nonhomeless group ($x^2 = 6.27$, $df = 1$, $p = 0.01$). The two homeless status groups were indistinguishable from each other by psychopathology rating (Table 2). Paranoid delusions and command auditory hallucinations occurred in the same proportions in the two groups.

Discussion

Homelessness has been clearly associated with criminal behavior among the mentally ill. However, the relative contributions of homelessness, mental illness, substance abuse, prior offense history, and psychiatric symptomatology have not been adequately studied. This study represents an attempt to look at the contributions of these different variables.

In our population of mentally ill offenders we found a clear link between dual diagnosis (schizophrenia *and* substance abuse) and homelessness. We found that the extent of psychiatric symptomatology was not related to domicility status. Thus, it was not the more disturbed who ended up living on the street, but those who had coexisting substance abuse problems.

TABLE 2—*Variables associated with crime by homeless status.*

Parameter	Description	Homeless (n = 40)	Domiciled (n = 25)
History of substance abuse	yes	30	13
	no	7	6
Intoxicated at time of offense	yes	19	9
	no	9	6
Prior offenses[a]	none	2	14
	violent	3	2
	non-violent	6	1
	mixed	17	5
Psychiatric symptom rating		9.4 ±1.5	9.9 ±1.5

[a] $p < 0.05$.

In the group of mentally ill offenders, the subgroup who were homeless at the time of the instant offense were more likely to have had a history of prior offenses. This would suggest that a good way to decrease the criminal activity among the mentally ill is to prevent homelessness. This finding has important implications for social policy makers and civic planners. The need to remedy the problem of homelessness among the mentally ill is clear.

The univariate approach of our study limits its generalizability. Further work should be carried out using a multivariate approach to elicit possible interactions between the variables of substance abuse, prior criminal activity, and psychopathology in determining homelessness among the mentally ill.

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Erratum

In the article, "The Trial of Louis Riel: a Study in Canadian Psychiatry" (Vol. 37, No. 3, May 1992, p. 852), I erred in stating that Valentine Shortis was found not guilty of homicide, a verdict supported by the cabinet. In actuality, the insanity defense failed and Shortis was sentenced to death. The cabinet was evenly split over a recommendation for clemency. The Governor General, Lord Aberdeen, then commuted Shortis to "imprisonment for life as a *criminal lunatic* (italics mine), or otherwise as may be found fitting." This action exacerbated the discontent of French-Canadians over the Riel case. This decision in the Shortis case may have been a factor in the election of a Liberal, Wilfrid Laurier, who became the first French-Canadian prime minister of Canada in 1986.

Shortis remained incarcerated for 42 years; in the earlier years, he was frequently described as mentally ill. In his later years, he apparently functioned quite well and was released at age 62 in 1937; in 1941 he died suddenly of a heart attack.

Both the Jackson and Shortis cases reflect the fact that Canadian authorities were not adverse to considering the impact of mental illness in deciding the disposition of offenders, a step that was rejected in the Riel case.

I wish to thank Abraham L. Halpern, M.D., for bringing this error to my attention.

Irwin N. Perr, MD, JD

Erratum

The articles that appeared in the May issue of the journal under the Psychiatry and Behavioral Science Section Awards were erroneously labeled Case Reports on the title page.