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## Guilty By Reason of Insanity: Unforeseen Consequences of California's Deinstitutionalization Policy

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# Guilty By Reason of Insanity: Unforeseen Consequences of California's Deinstitutionalization Policy

## **Abstract**

Beginning with the passage of the Lanterman-Petris- Short Act in 1969, deinstitutionalization in California has had a devastating effect on the mentally ill. Instead of affording the mentally ill with more rights and protections, the process of shutting down state psychiatric hospitals and impeding psychiatric care for those in need caused a cascade effect leading to an increase of homelessness and incarceration. Over the past four decades, prisons and jails in California have become the de facto state mental hospitals, with severely mentally ill individuals having nearly a four-to-one chance of ending up in jail or prison over a psychiatric facility of some variety. This restructuring of mental health services has contributed to the ever-increasing problem of mass incarceration – a problem that has reached epidemic levels in recent years. To that end, solutions to this problem include: community-based mental health services, reopening some state psychiatric hospitals with greater oversight, funding medical research into improved treatment options, and community education aimed at fostering a greater understanding of mental health issues.

## **Keywords**

deinstitutionalization, mental health

Guilty By Reason of Insanity: Unforeseen  
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*Jen Rushforth*

**Abstract**

Beginning with the passage of the Lanterman-Petris-Short Act in 1969, deinstitutionalization in California has had a devastating effect on the mentally ill. Instead of affording the mentally ill with more rights and protections, the process of shutting down state psychiatric hospitals and impeding psychiatric care for those in need caused a cascade effect leading to an increase of homelessness and incarceration. Over the past four decades, prisons and jails in California have become the de facto state mental hospitals, with severely mentally ill individuals having nearly a four-to-one chance of ending up in jail or prison over a psychiatric facility of some variety. This restructuring of mental health services has contributed to the ever-increasing problem of mass incarceration – a problem that has reached epidemic levels in recent years. To that end, solutions to this problem include: community-based mental health services, reopening some state psychiatric hospitals with greater oversight, funding medical research into improved treatment options, and community education aimed at fostering a greater understanding of mental health issues.

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## **Introduction**

Beginning with the passage of the Lanterman-Petris-Short Act in 1969, deinstitutionalization in California has had a devastating effect on the mentally ill. Instead of affording the mentally ill with more rights and protections that had been absent during the institutionalization period, the process of shutting down state psychiatric hospitals and impeding psychiatric care for those in need caused a cascade effect leading to an increase of homelessness and incarceration. Over the past four decades, prisons and jails in California have become the de facto state mental hospitals. Currently, seriously mentally ill individuals have nearly a four-to-one chance of ending up in jail or prison over a psychiatric facility of some variety (Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010). This restructuring of mental health services has contributed to the ever-increasing problem of mass incarceration – a problem that has reached epidemic levels in recent years.

### **Institutionalization and its Social Effects**

A discussion of deinstitutionalization cannot occur without first discussing the situation from which it arose. In the 19<sup>th</sup> century, social activists in the United States sought to remove the mentally ill from prisons and have them treated in dedicated psychiatric facilities (Quanbeck, Frye, & Altshuler, 2003; Torrey et al., 2010). By 1880, 40 state psychiatric hospitals had been built in the country, and the population of mentally ill prisoners was down to 0.7% of the total inmate population (Quanbeck et al., 2003). Between 1880 and 1960, the percentage of mentally ill prisoners ranged from 0.7% to 1.5% (Torrey et al., 2010). During the first half of the 20<sup>th</sup> century, treatments, such as electroconvulsive therapy and sterilization, were often involuntary and commitment to the institution was

usually indefinite (Rushforth, 2014). Such treatment, along with the continued use of indefinite, involuntary confinement led to an outcry by activists to shut down the public psychiatric hospitals (Torrey et al., 2010).

### **History of Deinstitutionalization**

Deinstitutionalization on a mass scale began in the United States during the 1950s and 1960s (Torrey et al., 2010). Arguments in favor of closing state psychiatric hospitals came from both fiscal conservatives, who saw it as a cost-saving measure, and civil rights activists, who were interested in preserving the rights of the mentally ill. California began reducing its state psychiatric hospital population in the mid-1950s under Governor Knight, and continued into the 1960s under Governor Pat Brown. However, it was Governor Reagan who was determined to close them completely, even after the state hospitals were half empty (Torrey et al., 2010). In 1969, Governor Reagan signed the Lanterman-Petris-Short Act.

### **Lanterman-Petris-Short Act**

After its passage, the Lanterman-Petris-Short Act was codified in the California Welfare and Institutions Code as sections 5000 through 5585. The legislative intent of the act was:

- (a) To end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, and to eliminate legal disabilities.
- (b) To provide prompt evaluation and treatment of persons with mental health disorders or impaired by chronic alcoholism.
- (c) To guarantee and protect public safety.

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- (d) To safeguard individual rights through judicial review.
- (e) To provide individualized treatment, supervision, and placement services by a conservatorship program for persons who are gravely disabled.
- (f) To encourage the full use of all existing agencies, professional personnel, and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures.
- (g) To protect persons with mental health disorders and developmental disabilities from criminal acts.
- (h) To provide consistent standards for protection of the personal rights of persons receiving services under this part and under Part 1.5 (commencing with Section 5585).
- (i) To provide services in the least restrictive setting appropriate to the needs of each person receiving services under this part and under Part 1.5 (commencing with Section 5585). (California Welfare & Institutions Code, § 5001).

Thus, the requirements for civil commitment of mentally ill individuals were drastically changed.

Those deemed to be a danger to themselves or others, or considered “gravely disabled,” can be taken into custody and placed on a 72-hour psychiatric hold for evaluation and treatment (California Welfare & Institutions Code, § 5150). These three day holds can be extended to no more than fourteen days after the initial evaluation under the following conditions: the individuals are still deemed to be a danger to themselves or others, or are still considered “gravely disabled”; the facility in which the individuals had been placed for the three day hold is

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willing to admit them for the extended period; and they are unwilling or unable to participate in treatment voluntarily (California Welfare & Institutions Code § 5250).

For the purposes of the Welfare and Institutions Code, “gravely disabled” has been determined to apply to those individuals suffering from a mental illness or chronic alcoholism, who, due to such conditions, cannot provide the basic needs of food, shelter, and clothing for themselves. The term has also been applied to defendants who have been found not competent to stand trial, whose indictments involve serious felonies of either homicide, grave bodily injury, or serious threats against another, whose indictments are still pending before the court, and who are unable to understand the charges against them and cannot competently assist in their own defense (California Welfare & Institutions Code, § 5008).

After these seventeen days, individuals cannot be held without demonstration of suicidal behavior, which can add an additional 14 day hold, extending the involuntary commitment to 31 days (California Welfare & Institutions Code, § 5260). There is a judicial commitment process that can extend the hold of an individual who has not demonstrated suicidal behavior for no more than 30 days under the following conditions: a finding of continued grave disability; a continued lack of willingness to voluntarily participate in treatment; and the condition of patients must be examined every 10 days to determine if they still meet the criteria for the 30 day extended hold (California Welfare & Institutions Code, § 5270.15). Individuals who, after the end of the 14 day hold, have been determined to be an immediate threat by attempting, inflicting, or threatening physical harm on another may be held for up to 180 days (California Welfare & Institutions Code, § 5300).

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Conservatorships – a legal situation in which an adult is found incapable of caring for themselves, and another is appointed to act in their stead in many matters – may be appointed by the court to individuals held under the aforementioned sections who remain gravely disabled and unwilling to participate voluntarily in treatment. Individuals for whom conservatorship is sought are entitled to petition for a jury trial, to commence not more than ten days after said petition has been filed (California Welfare & Institutions Code, § 5350). If a temporary conservatorship is granted, it lasts for 30 days, and may be extended for no more than six months (California Welfare & Institutions Code, § 5352.1). When a conservatorship that is not considered temporary by the court is granted, it is automatically terminated after a year (California Welfare & Institutions Code, § 5361). If individuals have been placed under conservatorship, they have the right to appeal the decision, however, the conservatorship remains in place unless the appellate court issues a stay during the appeal process (California Welfare & Institutions Code, § 5352.4). After conservatorship is granted, conservators must place their conservatees in the least restrictive treatment environments possible, with placements in homes of private parties being preferable (California Welfare & Institutions Code, § 5358).

Individuals held involuntarily have the right to petition the court for their release at any point during their hold (California Welfare & Institutions Code, § 5275).

### **Effects of the Lanterman-Petris-Short Act**

With the tightening of regulations on civil commitments for the mentally ill, and the shutting down of most of the state psychiatric hospitals, many severely mentally ill individuals were left with little recourse for treatment. Abramson (1972)



noted an increase in arrests of mentally ill individuals for crimes such as public drunkenness, disorderly conduct, malicious mischief, and possession of marijuana. In his study of San Mateo County, he noted that in 1968, the year before the enactment of the Lanterman-Petris-Short Act, the county committed 16 individuals to mental institutions for incompetency to stand trial out of 11,000 issued criminal complaints. In 1970, however, that rate changed to 33 commitments per 15,000 criminal complaints. The increase in criminal complaints issued was 36% (Abramson, 1972). If the rates had remained consistent, one would expect approximately 22 commitments per 15,000 complaints. Thirty-three commitments per 15,000 complaints represents a 52% increase in commitments of individuals not competent to stand trial.

Thus began the criminalization of the mentally ill. Without functioning state hospitals and avenues for treatment for those not considered a danger, or gravely disabled, the mentally ill often had nowhere to go, except the streets. Abramson (1972) noted that mentally ill individuals who were often picked up by authorities for various minor crimes attributed to self-medication. Public drunkenness and possession of marijuana are the two that generally fall under the “self-medication” category. Many individuals with mental illnesses who do not have access to proper treatment, or do not fully understand their illness, self-medicate with drugs and alcohol.

The incarceration of mentally ill prisoners increased as state hospitals continued to close. A theory demonstrated by Penrose in 1939 states that prison populations and psychiatric institution populations are inversely correlated: as one increases, the other decreases (Quanbeck et al., 2003; Torrey et al., 2010). All the data on the incarceration of seriously mentally ill

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individuals after deinstitutionalization support Penrose's conclusion. Recent data gathered by the Substance Abuse and Mental Health Service Administration (2011) using the National Survey on Drug Use and Health [NSDUH] estimate the incidence of serious mental illness in the general population to be 4.4%. As of 2012, there were approximately 120,000 inmates in California prisons (California Department of Corrections and Rehabilitation, 2012). If the NSDUH's estimations bore out in California's prisons, one would expect to see approximately 5,300 seriously mentally ill inmates. However, currently in California, an estimated 16% of the prison population suffers from serious mental illness (Ball, 2007). The number of seriously mentally ill inmates in California's prisons is approximately 364% of the expected incidence in the general population. If one takes the data on the percentage of mentally ill in prisons prior to deinstitutionalization even at its height, 1.5% of the inmates (Torrey et al., 2010), and compares it to the data from California, California's incarceration rate of seriously mentally ill individuals is 1067% of what it was prior to deinstitutionalization. Looking at it another way, California currently incarcerates 19,000 seriously mentally ill individuals, nearly 14,000 of whom are there because state psychiatric hospitals were closed.

### **Current Availability of Psychiatric Beds in California**

There are approximately 38 million people in California today, and if one uses the NSDUH (2011) 4.4% estimate for the number of seriously mentally ill individuals in a population, the number of seriously mentally ill people in California is approximately 1.67 million. When treating a chronic condition, medical care is expensive and continues to rise. Long-term care for a severe psychiatric disorder that may necessitate

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hospitalization can realistically bankrupt an individual, if one does not have access to public mental health facilities – which are limited – and if the insurance in question has limits on the amount of mental health care someone can receive during a calendar year.

**Psychiatric beds administered by the state's Department of State Hospitals.**

Currently, there are eight state hospitals administered by the Department of State Hospitals (DSH) – Atascadero, Coalinga, Metropolitan, Napa, Patton, Salinas Valley, Stockton, and Vacaville. Among these eight hospitals, there is an approximate 10,000-bed capacity. However, only Metropolitan State Hospital allows for voluntary admissions. Its capacity is approximately 1,200 beds, and it also treats patients under civil commitments and forensic commitments – including commitments for those not deemed competent to stand trial, those who have been deemed not guilty by reason of insanity, prisoners in need of psychiatric treatment, and those who have been paroled but are still considered a danger (California Department of State Hospitals, 2012). This reduces the actual amount of space to admit patients on a voluntary basis. Metropolitan State Hospital is located in Los Angeles County, which makes the possibility of voluntary admission to an affordable, public psychiatric hospital for the mentally ill outside that area untenable.

**Psychiatric beds administered by other agencies – public and private.**

Currently, aside from the eight aforementioned DSH hospitals, California has a total of 49 dedicated public psychiatric facilities, as well as 450 psychiatric wards within public general hospitals. Among these wards, approximately

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6,400 beds are available for patients. According to the California Hospital Association (2013), the bare minimum of public psychiatric beds needed in the state is 50 per 100,000 individuals, based on the hospitalization needs of individuals, average length of hospitalization, and contingent on available outpatient services. With the current population of California at approximately 38 million, and the number of public beds available, the state's ratio is at 16.76 per 100,000 (California Hospital Association, 2013). The state is currently only at 33.5% of the minimum standard of care in public psychiatric beds.

The approximate number of private psychiatric beds in California is 6,500 (Lauer, 2011). Even if one were to combine the number of private beds and the number of public beds, the total would only reach approximately 12,900. That combination would raise the ratio of total psychiatric beds in California to 33.91 per 100,000. Even that is only 67.8% of the minimum threshold cited by experts in the California Hospital Association's (2013) study.

Put simply, there is 1 public psychiatric bed for every 5,975 individuals in the state of California. There is 1 private psychiatric bed for every 5,982 Californians. All told, there is 1 psychiatric bed for every 2,962 Californians. The state is asking its people to play musical beds, and to not receive care desperately needed, or worse, to receive it in prisons – which is often substandard at best, as *Brown v. Plata* (2011) and other cases have demonstrated.

### **Recommendations**

There are four major recommendations to resolve the current crisis deinstitutionalization has caused in regards to criminalizing the mentally ill in California: reopening state psychiatric hospitals with greater oversight; community-based

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mental health services; funding medical research into improved treatment options; and education aimed at fostering a greater understanding of mental health issues.

It must be said that the recommendation to reopen state psychiatric hospitals comes with the strongest of admonitions: the rights and freedom of the patients in question must be respected. This is not a recommendation to take the seriously mentally ill and force them into institutions against their will. Such a move would violate the due process rights of the mentally ill, as well as violate medical ethics (Rushforth, 2014). Deinstitutionalization happened because the rights and liberty of the mentally ill were suppressed and disregarded. If state hospitals are to operate again, in any capacity, the true intention of deinstitutionalization must be respected. The Lanterman-Petris-Short Act, at its heart, sought to protect the mentally ill from involuntary treatment and indefinite commitment (California Welfare & Institutions Code § 5001). The Supreme Court's holding in *O'Connor v. Donaldson* (1975) stating it is unconstitutional for a state to confine in an institution an individual not deemed dangerous, or gravely disabled, must also be taken into account when discussing the reopening of state hospitals. The combination of the intent of the Lanterman-Petris-Short Act and the holding in *O'Connor* make it clear that, if state hospitals are reopened, patients within them will be properly protected. However, the issue will be in opening hospitals again. Access to public hospitals is, as seen, scarce. At a bare minimum, to reach the threshold of 50 public beds per 100,000 cited by experts in the California Hospital Association (2013) study, California needs to add approximately 12,600 public psychiatric beds. In California's favor, as recently as April 2014, the state did authorize a \$75 million grant for mental health

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services among twenty-eight counties (Romney, 2014). Perhaps this spending signals a shift in how California budgets for its mental health.

Community-based mental health options come in many forms. Funding for various outpatient treatment programs must be obtained. In Gheel, Belgium, community members foster seriously mentally ill individuals in their homes, giving them the opportunity to be a part of the community, and to have a committed network of social support and love that perhaps would not exist otherwise (Goldstein & Godemont, 2003). For the seriously mentally ill who have no support system, and would be considered gravely disabled by their inability to care for themselves, a similar program would be immensely beneficial. It would avoid long-term hospitalizations, as well as create social bonds that can aid in treatment. This program may seem idealistic and expensive, but it can easily be funded through the budgetary savings made by decarcerating the seriously mentally ill prison population. As to idealism, families are often willing to foster children with physical and mental disabilities, it stands to reason, therefore, the same compassion and love can be found to foster adults in need.

Supported living services agencies are another community alternative. These agencies help individuals with disabilities of all varieties live independently, with as much assistance as is needed. The level of assistance needed varies from individual to individual. Most, if not all, require a live-in assistant to be available for emergencies, and when other staff members are not on duty. Assistance can range from transportation and help with activities such as cooking and grocery shopping, to personal care and help with personal mobility. This provides individuals the opportunity to live on

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their own, while still having assistance available when necessary. The difference between this and fostering individuals in the community is that with supported living services, individuals are not living with community members, they have their own home, and assistance is being paid for, privately – usually by a combination of family support and Social Security disability benefits. Obviously, supported living services is less accessible for individuals without the necessary funds, but for those who can afford it, it provides an alternative to group homes, hospitals, and even living with family for life.

There are currently no cures for mental illness, yet the amount of knowledge the medical community has about the brain pales in comparison to the amount of knowledge it does not have about it. However, medical science is progressing at an astonishing speed. The amount of funding, both public and private, that goes into research for mental health must be enough to make it possible to find better treatments, and one day, cures. This will eventually alleviate a great deal of the burden on the prison system, but more importantly, it will be of some of the greatest help to people.

The final, and perhaps most important, recommendation is to educate the general public on mental illness in an attempt to foster a greater understanding, and to lessen the stigma of it. Studies have shown the mentally ill are often stigmatized due to their illness, often because of stereotypes surrounding it. This stigmatization leads to a deterioration of social networks, including eroding family structures and drastically reducing job opportunities. Only 30% of the mentally ill actually seek treatment. The stigma associated with mental illness is such that people will seek to deny their status as mentally ill by actively avoiding institutions, such as mental health care, that would label

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them as such. This stigmatization and avoidance is what most affects mental health treatment (Corrigan, 2004).

Educating the general public on the realities of mental illness would go a long way to alleviate the stigmatization felt by the mentally ill, and perhaps make receiving treatment a more feasible option for people. To educate the public, a section must be added to the curriculum in both middle school and high school health classes on the nature and function of mental illness, its effects on people and their families, and tolerance and acceptance to those affected. Outside of the public sphere, law enforcement must be trained on how to properly interact with the mentally ill, especially those with serious mental illnesses, and to treat them not as criminals, but as those in need of medical help. *San Francisco v. Sheehan* will be heard before the Supreme Court beginning on March, 23, 2015 as to whether or not the reasonable accommodations requirement in Title II of the Americans with Disabilities Act applies to interactions with police; San Francisco appealed the decision of the 9<sup>th</sup> Circuit Court of Appeals which held that Title II does apply to arrests (American Civil Liberties Union, 2015; *Sheehan v. San Francisco*, 2014). Affirming the Circuit Court's decision will make a serious change in the way law enforcement interacts with the mentally ill, especially those in emergency psychiatric situations; however, a decision in favor of San Francisco will set back the rights of everyone protected by the Americans with Disabilities Act. Reducing the stigma of mental illness and educating the public will make receiving treatment for mental illness easier, as well as go a long way toward reducing the damage to social networks that stigmatization causes.



### **Conclusion**

Deinstitutionalization had the very best intentions when it was conceived: to end the involuntary treatment, and indefinite confinement of the seriously mentally ill. That was one effect of deinstitutionalization, however, it was not the only effect. During the four decades since deinstitutionalization began, the number of seriously mentally ill prisoners has increased exponentially, now reaching 16% of the total prison population, instead of the mere 1.5% it was at prior to deinstitutionalization (Ball, 2007; Torrey et al., 2010). Given the generally accepted number of people under carceral supervision – prison, jail, parole, and probation – of seven million (The Sentencing Project, 2014), a total of 1.1 million seriously mentally ill individuals are under carceral supervision at any given moment in the United States today. The United States has a population of approximately 318 million people, using the NSDUH (2011) estimation of 4.4%, approximately 14 million of those have a serious mental illness. Currently, 7.9% of the seriously mentally ill population of the entire United States is now under carceral supervision. That is 527% of the 1.5% incarceration rate of the seriously mentally ill just one decade prior to deinstitutionalization. Something must be done to end this: reopen state psychiatric hospitals, fund community mental health programs, fund medical research for treatment options, and educate the public on mental health. Although nothing can erase 40 years of a system gone horribly wrong, implementing these changes can at least address this injustice in such a way so that it will not happen again.

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