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WHY ARE CALIFORNIA'S PRISONS AND STREETS FILLED WITH MORE MENTALLY ILL THAN ITS HOSPITALS?: CALIFORNIA'S DEINSTITUTIONALIZATION MOVEMENT

Julia Schon

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**WHY ARE CALIFORNIA’S PRISONS AND STREETS
FILLED WITH MORE MENTALLY ILL THAN ITS
HOSPITALS?**

**CALIFORNIA’S DEINSTITUTIONALIZATION
MOVEMENT**

*Julia Schon**

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I. INTRODUCTION

Mental illness is not a recent phenomenon—it has filled the pages of popular novels and history books for decades. From the character Bertha in *Jane Eyre*¹ to the Salem witch trials,² society has traditionally shunned and locked away those who are “plagued” by lunacy. Despite our move into the twenty-first century, the way in which the United States deals with its mentally ill population has not changed dramatically. Consequently, mental illness fills the pages of our court dockets and fills the lines of our local soup kitchens.

Today, over 43.8 million people, or one in five adults, experience mental illness in a given year.³ Approximately seventy to ninety percent of individuals who receive adequate mental health services experience a “significant reduction” in symptoms and an overall improved quality of life.⁴ However, despite these promising statistics, only forty percent of those suffering from a mental illness received treatment or services in the last year.⁵ This means that sixty percent of mentally ill individuals are left untreated in the United States.⁶ Thus, it is no surprise that the United States’ prison and homeless populations consist of disproportionately high numbers of mentally ill individuals.⁷

The United States’ mental health policy has been “characterized by a cyclical pattern of institutional reforms,”⁸ and California’s own policy

1. CHARLOTTE BRONTË, *JANE EYRE* (Harper & Brothers 1848).

2. Beatrix Quintanilla, *Witchcraft or Mental Illness?*, *PSYCHIATRIC TIMES* (June 21, 2010), <http://www.psychiatrictimes.com/schizoaffective/witchcraft-or-mental-illness>.

3. Nat’l All. on Mental Illness, *Mental Health Facts in America*, <https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf>.

4. Olga L. Kofman, *Deinstitutionalization and Its Discontents: American Mental Health Policy Reform 5* (2012) (unpublished B.A. thesis, Claremont McKenna College) (Open Access Senior Thesis, http://scholarship.claremont.edu/cmc_theses/342/).

5. See Nat’l All. on Mental Illness, *supra* note 3.

6. *Id.*

7. *Id.*

8. Howard H. Goldman & Joseph P. Morrissey, *The Alchemy of Mental Health Policy: Homelessness and the Fourth Cycle of Reform*, *AM. J. PUB. HEALTH* 727-31 (1985), <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.75.7.727>.

has coincided with these national “patterns”—both the humane and inhumane.⁹ As current law and policy stand, both in California and at the federal level, state prisons, jails, and streets have become America’s “new asylums.”¹⁰ Consequently, many mentally ill individuals are locked away in a cycle of homelessness and incarceration.¹¹

This note will outline the history of mental health policy and practice within the United States and California, as well as the incidental consequences of these policies. This note will proceed in four parts. Part I will provide an in-depth look at mental health policy, specifically the deinstitutionalization movement. This history will be shown by an examination of nationwide policies, as well as examination of policies specific to California. Part II will highlight the disproportionate number of mentally ill individuals in the United States’ and California’s prison and homeless populations. Part III will link this disproportionate prison and homeless populations to past and current mental health policy. Lastly, as means to remedy the adverse consequences of the deinstitutionalization movement, Part IV will propose potential changes to criminal prosecution methods and identify a new funding scheme for mental health treatment options.

II. BACKGROUND

A. The Creation of State Psychiatric Facilities in the United States

As early as 1694, Massachusetts Bay Colony passed legislation that authorized the incarceration of any person “lunatic and so furiously mad as to rend it dangerous to the peace or the safety of the good people for such lunatic person to go at large.”¹² In Colonial America, family members or the local community predominately cared for the docile mentally ill.¹³ However, due to the implementation of poor laws, it became commonplace to incarcerate those debilitated by mental illness.¹⁴ Consequently, prisons and jails primarily incapacitated the mentally ill rather than provided treatment and care.¹⁵ The inhumane

9. Kofman, *supra* note 4, at 7.

10. TREATMENT ADVOC. CTR., THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN PRISONS AND JAILS: A STATE SURVEY 6 (2014), <http://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf>.

11. *See id.* at 6; Kofman, *supra* note 4, at 8.

12. TREATMENT ADVOC. CTR., *supra* note 10, at 9.

13. Bernard E. Harcourt, *Reducing Mass Incarceration: Lessons from the Deinstitutionalization of Mental Hospitals in the 1960s*, 9 OHIO ST. J. CRIM. L. 53, 61 (2011).

14. PBS, *Deinstitutionalization: A Psychiatric Titanic*, FRONTLINE (May 10, 2005), <https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html>.

15. Harcourt, *supra* note 13, at 61.

conditions of these local prisons and jails ignited a crusade among social activists, specifically, a movement to remove the mentally ill from the confines of criminal imprisonment.¹⁶

In 1827, Louis Dwight's¹⁷ advocacy led to the creation of a committee amongst the Massachusetts legislature whose purpose was to inspect the conditions of state prisons and local jails.¹⁸ After weeks of investigation, the committee made alarming reports.¹⁹ The committee indicated that, "[l]ess attention is paid to their [the mentally ill's] cleanliness and comfort than to the wild beasts in their cages, which are kept for show."²⁰ As a result of these findings, Massachusetts planned to build its first hospital dedicated to psychiatric treatment.²¹

By 1833, the efforts of Louis Dwight and other activists alike helped to open the United States' first psychiatric hospital in Worcester, Massachusetts.²² After the hospital's unveiling, "more than half of the 164 patients received during that year came from jails, almshouses, or houses of correction."²³ Around this time, Dorothea Dix made it her mission to establish more psychiatric hospitals across the country after she witnessed firsthand the deplorable living conditions of the incarcerated mentally ill.²⁴ During the following year, Dix led a nationwide crusade for greater mental health rights.²⁵ By 1847, she visited over three hundred local jails and states prisons.²⁶ As a result of Dorothea Dix's efforts, thirty-two mental hospitals were established.²⁷

By 1880, there were seventy-five state facilities in the United States dedicated to psychiatric treatment.²⁸ The United States' 1880 census

16. PBS, *supra* note 14; Jen Rushforth, *Guilty By Reason of Insanity: Unforeseen Consequences of California's Deinstitutionalization Policy*, 3 THEMIS 28, 29 (2015), <http://scholarworks.sjsu.edu/cgi/viewcontent.cgi?article=1023&context=themis>.

17. Louis Dwight was a key figure in prison and asylum reform. While passing out bibles in prisons, Louis Dwight saw first-hand the terrible conditions prisoners faced. More specifically, his investigations revealed the particularly terrible conditions of imprisoned mentally ill individuals. Consequently, he actively pursued jail and prison reforms that provided mentally ill prisoners with better care. TREATMENT ADVOC. CTR., *supra* note 10, at 9.

18. TREATMENT ADVOC. CTR., *supra* note 10, at 9.

19. *Id.*

20. *Id.*

21. *Id.* at 10.

22. PBS, *supra* note 14; TREATMENT ADVOC. CTR., *supra* note 10, at 10.

23. GERALD N. CROB, *MENTAL INSTITUTIONS IN AMERICA: SOCIAL POLICY TO 1875* 116 (FREE PRESS 1973).

24. PBS, *supra* note 14.

25. TREATMENT ADVOC. CTR., *supra* note 10, at 10.

26. *Id.* at 11.

27. Vasantha Reddi, *Dorothea Lynde Dix*, TRUTH ABOUT NURSING, <http://www.truthaboutnursing.org/press/pioneers/dix.html>.

28. PBS, *supra* note 14.

indicated that of the 91,959 “insane persons”: 41,083 were living at home, 40,942 were in hospitals, 9,302 were in almshouses, and only 397 were in jails.²⁹ Therefore, only 0.7 percent of the prison population consisted of mentally ill individuals.³⁰ Between 1880 to 1960, “the percentage of mentally ill prisoners ranged from 0.7% to 1.5%.”³¹

By 1960, the psychiatric institution population spiked to over a half a million.³² A number of theories attempt to explain this increase in psychiatric hospitalization. Some explanations include: “seven factors, . . . including importantly, (4) public and professional confidence in, and willingness to utilize, mental hospitals; (5) a broader conception of mental illness; (6) an increasingly long duration of stay [for mental illness recovery]; and (7) decreased tolerance for deviant behavior and perhaps higher rates of mental illness.”³³ While others believe the increasing psychiatric institutionalization arose from “the lack of effective and lasting treatments for serious mental illness, and the pressure brought to bear by families and communities who wanted a safe shelter for seriously disturbed members.”³⁴ However, during the 1950s and 1960s, a new movement was arising among activists—a movement that would drastically change psychiatric care.³⁵

B. The Creation of California's Psychiatric Facilities

In the early days of California, mental illness was of little concern.³⁶ However, this changed with the discovery of gold in 1848-1849.³⁷ The Gold Rush brought an influx of individuals both mad for gold and “mad” in the mind.³⁸ Consequently, in 1852, Stockton State Hospital was renamed California Asylum for the Insane and became the first psychiatric hospital in the West.³⁹ Thus, mental health reform became a bicoastal movement. As a result of overcrowding in California Asylum

29. *Id.*

30. *Id.*

31. Rushforth, *supra* note 16, at 29.

32. Harcourt, *supra* note 13, at 64.

33. *Id.*

34. *Id.*

35. Rushforth, *supra* note 16, at 30.

36. Alva S. Klotter, *California Mental Hospitals*, 45(2) BULL. OF THE MED. LIBR. ASS'N 159 (1957), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC200107/pdf/mlab00212-0037.pdf>.

37. *Id.*

38. *Id.*

39. *Id.*

for the Insane, California opened its second state psychiatric hospital in Napa, California by 1873.⁴⁰

After years of lobotomies and electroshock therapy, the pharmaceutical treatment Chlorpromazine was introduced into California's psychiatric hospitals.⁴¹ By 1957, California had fourteen hospitals for the mentally ill that housed about 48,000 patients.⁴² During this same year, California passed the Short-Doyle Act, which provided funding for mental health community centers.⁴³ Moreover, this legislation encouraged the treatment of psychiatric patients within their home community, rather than in state hospitals.⁴⁴ However, psychiatric care would never be the same after Ronald Reagan passed the Lanterman-Petris-Short Act in 1967, which ended involuntary psychiatric commitment.⁴⁵

C. The Deinstitutionalization Movement: Its Causes and Course

The most notable causes attributed towards deinstitutionalization include: medical advancements in antipsychotic drug treatment, a new humanitarian agenda, new mental health legislation, and a push towards fiscal conservatism. Due to these driving forces, deinstitutionalization drastically changed mental health treatment by decreasing in-patient services.

1. What is the Deinstitutionalization Movement?

Deinstitutionalization is the name given to the mass movement of mentally ill patients out of psychiatric hospitals and into alternative community facilities.⁴⁶ From the early 1970s until the 1990s, the deinstitutionalization movement focused on two major campaigns: the closure of state mental hospitals and the closure of state facilities housing those with developmental disabilities.⁴⁷ From 1955 to 1976, the number of patients in state psychiatric hospitals decreased from 559,000 to

40. *Mental Health California Timeline (1850s to present)*, HOPESTORY: HISTORY OF PUBLIC MENTAL HEALTH CARE, <http://histpubmh.semel.ucla.edu/mental-health-timeline> (last visited Jan. 29, 2018).

41. *Id.*

42. Klotter, *supra* note 36.

43. *Mental Health California Timeline*, *supra* note 40.

44. Alfred Auerback, *The Short-Doyle-Act*, 90(5) CAL. MED. 335 (1959), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1577700/pdf/califmed00113-0095.pdf>; *Mental Health California Timeline*, *supra* note 40.

45. *Mental Health California Timeline*, *supra* note 40.

46. Rushforth, *supra* note 16.

47. Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 CARDOZO L. REV. 1, 7 (2012).

171,000,⁴⁸ and by 1985, the United States saw an eighty percent decline in these hospital populations.⁴⁹

2. *What Caused the Deinstitutionalization Movement?*

a. *Development of Antipsychotic Drugs*

Prior to the creation of antipsychotic drugs, most psychiatric treatments consisted of methods that would be considered unconventional by today's standards. The most commonly used treatments included electroshock therapy, insulin coma therapy, and lobotomies.⁵⁰ These methods involved serious side effects that could leave patients with permanent brain damage.⁵¹ Thus, when antipsychotic drugs were developed in 1954, the treatment of mental illness shifted dramatically.

The first widely available antipsychotic medication was Thorazine, which produced a tranquilizing effect on patients.⁵² By 1956, over two million individuals were prescribed Thorazine,⁵³ and at least thirty-seven states were using this new antipsychotic drug in their psychiatric hospitals.⁵⁴ Thorazine allowed mental hospitals to manage more patients with less staff⁵⁵ and provided hospitals with out-patient treatment options.⁵⁶

Although Thorazine by itself did not significantly reduce the patient population, several scholars link the drug's availability to notable impacts on public perception and policy.⁵⁷ Due to the positive impact of antipsychotic drugs on patients, many mental health professionals began to push for a mental health community care system, which consisted of out-patient services in local communities.⁵⁸ Additionally, in the eyes of the public, mentally ill individuals became treatable patients and were

48. Nancy K. Rhoden, *The Limits of Liberty: Deinstitutionalization, Homelessness, and Libertarian Theory*, 31 EMORY L.J. 375, 378 (1982).

49. E. Fuller Torrey, *Thirty Years of Shame: The Scandalous Neglect of the Mentally Ill Homeless*, 48 POL'Y REV. 10, 11 (1989) [hereinafter Torrey, *Thirty Years of Shame*].

50. William Gronfein, *Psychotropic Drugs and the Origins of Deinstitutionalization*, 32 SOC. PROBS. 437, 439 (1985) [hereinafter Gronfein, *Psychotropic Drugs*].

51. Harcourt, *supra* note 13, at 65.

52. E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS 99 (1998) [hereinafter TORREY, OUT OF THE SHADOWS].

53. *Id.*

54. Gronfein, *Psychotropic Drugs*, *supra* note 50, at 441.

55. See DAVID A. ROCHEFORT, FROM POORHOUSES TO HOMELESSNESS: POLICY ANALYSIS AND MENTAL HEALTH CARE 51 (1st ed. 1993).

56. Harcourt, *supra* note 13, at 66.

57. *Id.*

58. ROCHEFORT, *supra* note 55, at 38.

no longer incurable members of society.⁵⁹ Therefore, the development of antipsychotic drugs provided the mechanism to which the mentally ill could be removed from in-patient hospitals and placed into out-patient community programs.⁶⁰ Not only did antipsychotic medication provide the method, it also helped change the public's opinion on mental illness.⁶¹ Thus, antipsychotic medications provided both a new mechanism and a new willingness to treat mentally ill individuals amongst the community.

b. Humanitarian Efforts Through Litigation

During the 1950s and 1960s, a number of sociological studies were conducted within many of the state-run psychiatric hospitals.⁶² The results revealed a patient population subjected to deplorable living conditions and maltreatment.⁶³ These revelations both shocked and educated the public, and with the uncovering of these inhumane facilities came a wave of new activism.⁶⁴ Accordingly, activists viewed institutionalization as an intrusion on personal liberties and self-autonomy.⁶⁵ Consequently, activists sought reforms in mental health policy that would inhibit involuntary psychiatric commitment.⁶⁶ Thus, similar to the civil liberties movement, advocates for the mentally ill used litigation as a means to deteriorate the current institutions of psychiatric care.⁶⁷

First, litigation arose advocating for heightened due process protections against involuntary treatment in state mental hospitals.⁶⁸ Those confined to psychiatric facilities were most often admitted through involuntary commitment.⁶⁹ Thus, a heightened standard would have immediate effects on hospital populations.⁷⁰ By 1975, activists found success in the Supreme Court of the United States. In *O'Connor v. Donaldson*, the Supreme Court ruled that “a State cannot

59. *Id.* at 39.

60. Harcourt, *supra* note 13, at 66.

61. *Id.*

62. Rhoden, *supra* note 48, at 380.

63. See ERVING GOFFMAN, *ASYLUMS: ESSAYS ON THE SOCIAL SITUATION OF MENTAL PATIENTS AND OTHER INMATES* 12-74 (Transaction Publishers, 2d ed. 2009) (1961).

64. Rhoden, *supra* note 48, at 380-81.

65. Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CAL. L. REV. 54, 54-55 (1982).

66. *Id.*

67. Harcourt, *supra* note 13, at 70.

68. William Gronfein, *Incentives and Intentions in Mental Health Policy: A Comparison of Medicaid and Community Health Programs*, 26 J. HEALTH & SOC. BEHAV. 192, 194 (1985) [hereinafter Gronfein, *Incentives and Intentions*].

69. *Id.*

70. *Id.*

constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.”⁷¹

Second, litigation sought to challenge psychiatric institutions’ ability to provide minimally adequate care, or “right to treatment.”⁷² For example, in *Wyatt v. Stickney*, an Alabama circuit court found that an Alabama psychiatric facility failed to provide adequate care for civilly committed persons.⁷³ Consequently, those confined to this facility were released.⁷⁴

These litigation battles across the United States placed even greater pressure on state hospitals to release their existing patients and to turn away new admissions.⁷⁵ “While modern advocates of deinstitutionalization played an important role, it is probable that their demands were well received because other social conditions made deinstitutionalization a viable reform.”⁷⁶ Along with judicial avenues, advocates gained assistance through new government reforms in mental health policy.

c. Government Action and Legislation

In 1941, Rosemary Kennedy, sister to President John F. Kennedy, received a lobotomy, which was an “experimental procedure meant to make mentally ill patients more docile.”⁷⁷ The surgery left Rosemary almost completely disabled.⁷⁸ As a result of his first-hand experiences with Rosemary, President Kennedy became an avid supporter of the mentally ill.⁷⁹ In 1963, President Kennedy proposed a federal program called the Community Mental Health Center Act.⁸⁰ This program sought to reduce the population of state psychiatric hospitals with alternative treatment centers within local communities.⁸¹ Under the Community Health Center Act, the federal government would fund facilities that

71. *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975).

72. Harcourt, *supra* note 13, at 70.

73. *Wyatt v. Stickney*, 344 F. Supp. 373, 374 (M.D. Ala. 1972).

74. *Id.*

75. TORREY, *OUT OF THE SHADOWS*, *supra* note 52 at 194.

76. Rhoden, *supra* note 48, at 381.

77. Liz Mcneil, *The Untold Story of Rosemary Kennedy, and the Disastrous Lobotomy Ordered by Her Father*, PEOPLE MAG. (Sept. 2, 2015), <http://people.com/books/untold-story-of-rosemary-kennedy-and-her-disastrous-lobotomy/>.

78. *Id.*

79. Kofman, *supra* note 4, at 25.

80. Gronfein, *Incentives and Intentions*, *supra* 68, at 196.

81. *Id.*

provided out patient service to mentally ill individuals.⁸² However, Kennedy's Community Mental Health Center Act allocated zero federal funds to state hospitals.⁸³ President Kennedy asserted, "the mentally ill and the mentally retarded need no longer be alien to our affections or beyond the help of our communities."⁸⁴ President Kennedy partially attributed this initiative to the new antipsychotic medications which allowed the treatment of mentally ill individuals within their communities.⁸⁵ With the passage of President Kennedy's proposal came the "largest institutional migration that has ever occurred in this country."⁸⁶

With the changing attitude towards mental illness, deinstitutionalization increasingly became a part of many activists' and politicians' platforms. In 1965, the passage of Medicaid and Medicare created an even larger decline in state hospital populations.⁸⁷ Although Medicaid and Medicare were not passed to aid in deinstitutionalization, they nevertheless furthered the movement. This is because Medicaid and Medicare only covered treatment for private facilities, not state-run hospitals.⁸⁸ Thus, the expansion of these governmental programs intensified the deinstitutionalization movement by providing financial incentives to states. Consequently, the deinstitutionalization movement was driven by "a political alliance between civil libertarians and fiscal conservatives."⁸⁹

d. Cost-Shifting as a Factor

One of the driving forces of deinstitutionalization from the 1950s to the present is the attempt to shift costs from the states to the federal government.⁹⁰ In the first half of the 1900s, the number of patients in state-run facilities continually increased, leading to massive

82. Brian Prioleau, *Reflecting on JFK's Legacy of Community-based Care*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (last updated Apr. 19, 2016), <https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/jfk%E2%80%99s-legacy-community-based-care>.

83. See Kofman, *supra* note 4, at 25, 51.

84. See *id.* at 25.

85. ROCHEFORT, *supra* note 55, at 39.

86. Harcourt, *supra* note 13, at 53-54.

87. Kofman, *supra* note 4, at 28.

88. 42 U.S.C. § 1396(d)(a)(4), (a)(14), (a)(16), (a)(17), (h) (1976 & Supp. II 1978).

89. Bagenstos, *supra* note 47, at 4.

90. TREATMENT ADVOC. CTR., NO ROOM AT THE INN: TRENDS AND CONSEQUENCES OF CLOSING PUBLIC PSYCHIATRIC HOSPITALS (2005-2010) 16-17 (2012), http://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf [hereinafter NO ROOM AT THE INN].

overcrowding.⁹¹ As a result, states would either have to build new state psychiatric facilities or find ways to counteract the increasing trend.⁹² The new governmental programs and psychiatric medications mentioned above provided states with a means to deinstitutionalize.

For example, the Medicare and Medicaid programs provided financial incentives for states to move patients out of state facilities and into community treatment centers.⁹³ These programs provided a great incentive for states to move patients out of state mental hospitals and into federally subsidized institutions.⁹⁴ Ideally, these and other welfare programs would support released patients.⁹⁵

Additionally, when individuals reside in a state mental hospital, approximately seventy-nine percent of the costs associated with their treatment are accrued by the state.⁹⁶ However, when an individual seeks community treatment, the state will only cover approximately fifty-five percent of the cost.⁹⁷ Consequently, when a state facility closes a psychiatric bed, the state saves more money. Thus, economic motives fueled the deinstitutionalization movement well into the early 2000s.⁹⁸

e. Causes of Deinstitutionalization in California

Along with the major driving forces listed above, California faced its own social and political movements that ultimately led to its massive deinstitutionalization. Deinstitutionalization gained substantial support from two large political machines: the fiscal conservatives and the civil right activists.⁹⁹ The fiscal conservatives viewed deinstitutionalization as an opportunity to save state funds by relying on federally funded community health centers, and the civil right activists were interested in protecting the personal autonomy of the mentally ill.¹⁰⁰ Consequently, by 1950, California began reducing its state mental hospital populations.¹⁰¹

91. ANDREW T. SCULL, *DECARCERATION: COMMUNITY TREATMENT AND THE DEVIANT: A RADICAL VIEW* 66 (1977).

92. Rhoden, *supra* note 48, at 382.

93. Kofman, *supra* note 4, at 28.

94. Gronfein, *Incentives and Intentions*, *supra* note 68, at 200.

95. Rhoden, *supra* note 48, at 382.

96. NO ROOM AT THE INN, *supra* note 90, at 17.

97. *Id.*

98. *Id.*

99. Rushforth, *supra* note 16, at 30.

100. *Id.*

101. *Id.*

By the time Governor Ronald Reagan entered office, over half of the state mental hospitals were deinstitutionalized.¹⁰² However, despite this fact, Governor Reagan was still determined to change current mental health policy by permanently closing all state psychiatric hospitals.¹⁰³ In 1969, Governor Reagan signed the Lanterman-Petris-Short Act, which ended indefinite and involuntary commitment of mentally ill individuals except in the most extreme cases.¹⁰⁴ Subsequently, civil commitment of mentally ill individuals changed dramatically.¹⁰⁵ Those individuals who were deemed a danger to themselves and society could be placed on a three-day to fourteen-day psychiatric hold.¹⁰⁶ After the fourteen days, individuals cannot be held for longer without demonstration of suicidal behavior.¹⁰⁷ After the passage of the Lanterman-Petris-Short Act and the shutting down of most state psychiatric hospitals, many severely mentally ill individuals were left without treatment.

3. *The Course of the United States' Deinstitutionalization Movement*

Until 1970, the majority of discharged individuals from state psychiatric hospitals were those deemed most suitable for “community living” or the elderly.¹⁰⁸ Consequently, it was the post-1970 deinstitutionalization that ultimately became problematic.¹⁰⁹ By 1980, state mental hospital populations decreased from 560,000 to just over 130,000.¹¹⁰

The deinstitutionalization movement created today’s mental illness crisis by discharging people without providing the proper medication and rehabilitation services necessary for successful reintegration into communities.¹¹¹ Additionally, in-patient services were extremely limited due to bed shortages at public mental hospitals. Consequently,

102. E. Fuller Torrey, *Ronald Reagan's Shameful Legacy: Violence, the Homeless, Mental Illness*, SALON (Sept. 29, 2013), https://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness/.

103. Rushforth, *supra* note 16, at 30.

104. *Id.* at 30-32.

105. *Id.*

106. CAL. WELF. & INST. CODE, § 5150; CAL. WELF. & INST. CODE § 5250.

107. CAL. WELF. & INST. CODE, § 5260.

108. Alice S. Baum & Donald W. Burnes, *A National in Denial: The Truth About Homelessness*, 21 J. SOCIOLOGY & SOCIAL WELFARE 163 (1993).

109. *Id.*

110. Kofman, *supra* note 4, at 33.

111. PBS, *supra* note 14.

“approximately 2.2 million severely mentally ill people do not receive any psychiatric treatment.”¹¹²

The 1990s faced the advanced stages of deinstitutionalization when forty-four more state hospitals were closed and approximately forty-thousand more beds were lost throughout the United States.¹¹³ By 1994, state hospital populations decreased to 71,619 patients.¹¹⁴ Consequently, the United States faced an eighty-two percent deinstitutionalization rate.¹¹⁵ More troubling, the patients discharged during this period were the most difficult to manage and required the most treatment and care to ensure their wellbeing.¹¹⁶ These were the individuals that required the most treatment and care to ensure their wellbeing.¹¹⁷ However, by this point in the deinstitutionalization movement, the treatment and care facilities were on a continual decline. Consequently, many of those discharged during the 1990s fell between the cracks.

In 1994, the United States' population had risen to 260 million with approximately 71,619 individuals in state psychiatric hospitals.¹¹⁸ Thus, “92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994.”¹¹⁹ Additionally, most of the individuals who were deinstitutionalized suffered from chronic and severe mental illness.¹²⁰ Approximately, fifty to sixty percent of these individuals were diagnosed with schizophrenia.¹²¹

Mental health activists expected national spending on community mental health centers to grow as state institutions closed.¹²² However, activists would soon learn that these growths would fall short of the need. Moreover, the 2008 financial recession exacerbated the gap between the actual and necessary mental health funding.¹²³ Consequently, between 2009 and 2012, states cut public mental health spending by 4.35

112. *Id.*

113. E. FULLER TORREY, *AMERICAN PSYCHOSIS* 105 (2013) [hereinafter TORREY, *AMERICAN PSYCHOSIS*].

114. PBS, *supra* note 14.

115. *Id.*

116. *Id.*

117. *Id.* at 105-06.

118. PBS, *supra* note 14.

119. *Id.*

120. *Id.*

121. *Id.*

122. Michael Ollove, *Amid Shortage of Psychiatric Beds, Mentally Ill Face Long Waits for Treatment*, STATELINE (Aug. 2, 2016), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/08/02/amid-shortage-of-psychiatric-beds-mentally-ill-face-long-waits-for-treatment>.

123. *Id.*

billion.¹²⁴ By 2012, ninety-five percent of the nation's public psychiatric hospital beds have disappeared, and community care exists for fewer than half of the patients that need it.¹²⁵ "It's not like the patients have gone away. It's the treatment resources that have gone away," according to Renee Binder, President of the American Psychiatric Association.¹²⁶

Due unavailable funding, from 2005 to 2010, the number of state psychiatric beds decreased by fourteen percent.¹²⁷ This means the per capita state psychiatric bed populations have plummeted to 1850 levels, which means 14 beds per 100,000 population.¹²⁸ From 2010 to 2016, the number of state psychiatric beds decreased another thirteen percent.¹²⁹ Now, the United States only has 37,679 state psychiatric beds.¹³⁰ Consequently, "the loss of these beds has left the sickest of the sick without treatment" according to John Snook, Executive Director of the Treatment Advocacy Center.¹³¹ Today, no national legislation since JFK's Community Health Care Center Act has been proposed to solve the current mental health care policy problems.¹³²

4. *The Course of California's Deinstitutionalization Movement*

"California was at the frontline of deinstitutionalization."¹³³ Under Republican Governor Goodwin Knight, California's state psychiatric hospitals began to empty as early as the mid-1950s.¹³⁴ Deinstitutionalization continued into the 1960s and 1970s under Governor Edmund Brown and Governor Ronald Reagan.¹³⁵ In 1955, California had 37,211 patients in public mental hospitals.¹³⁶ After the enactment of the Lanterman-Petris-Short Act, California saw dramatic changes within its treatment of mental illnesses. As early as 1970-1972, California closed its first three state psychiatric hospitals.¹³⁷ By 1980,

124. *Id.*

125. NO ROOM AT THE INN, *supra* note 90, at 7.

126. Ollove, *supra* note 122.

127. NO ROOM AT THE INN, *supra* note 90, at 5.

128. *Id.*

129. Ollove, *supra* note 122.

130. *Id.*

131. *Id.*

132. Kofman, *supra* note 4, at 42.

133. Anastasia Cooper, *The Ongoing Correctional Chaos in Criminalizing Mental Illness: The Realignment's Effects on California Jails*, 24 HASTINGS WOMEN'S L.J. 339, 343 (2013).

134. *Id.*

135. *Id.*

136. PBS, *supra* note 14.

137. Sarah Moore, *A Brief History of Mental Health Care in California*, ABC10 (CONNECT) (last updated Apr. 17, 2018), <https://www.abc10.com/article/news/local/california/a-brief-history-of-mental-health-care-in-california/103-537434252>.

state mental hospital populations dropped to under 4,000 individuals.¹³⁸ Consequently, California had an effective deinstitutionalization rate of 89.8 percent.¹³⁹ While the goal of the deinstitutionalization movement was to offer improved mental health treatment, local communities lacked the necessary resources and infrastructure to deliver adequate services to discharged patients.¹⁴⁰

Currently, there are eight state hospitals in California: Atascadero, Coalinga, Metropolitan, Napa, Patton, Salinas Valley, Stockton, and Vacaville.¹⁴¹ Within these eight state psychiatric facilities, there are approximately ten thousand beds.¹⁴² These facilities generally treat patients under civil and forensic commitments, which includes those not competent to stand trial, those deemed guilty by reason of insanity, prisoners in need of psychiatric treatment, and those parolees who are still deemed a danger.¹⁴³ Only Metropolitan State Hospital in Los Angeles, whose bed capacity is approximately 1,200 beds, allows for voluntary admissions.¹⁴⁴ However, when civil and forensic commitments are accounted for, this 1,200 bed capacity goes down even further.¹⁴⁵

Although there are only eight state-run hospitals, California also has forty-nine psychiatric facilities and 450 psychiatric wards in general public hospitals, which provide approximately 6,400 beds.¹⁴⁶ “According to the California Hospital Association, the bare minimum of public psychiatric beds needed in the state is 50 per 100,000 individuals.”¹⁴⁷ This number is calculated based on the hospitalization needs of individuals, length of in-patient hospital stays, and the availability of out-patient services.¹⁴⁸ As of 2013, with California’s population at approximately thirty-eight million, the state’s bed to population allocation is at 16.76 per 100,000 individuals.¹⁴⁹ Therefore, California is “only at 33.5% of the minimum standard of care in public psychiatric beds.”¹⁵⁰ Additionally, in twenty-five counties, there are no

138. Kofman, *supra* note 4, at 46.

139. *See id.*

140. Mistique Felton, *Proposition 63, The Mental Health Services Act*, THE NICHOLAS C. PETRIS CTR. ON HEALTH CARE MARKETS & CONSUMER WELFARE 2, http://petris.org/wp-content/uploads/2013/02/PetrisBriefingPaper_MentalHealthServicesAct.pdf.

141. Rushforth, *supra* note 16, at 36.

142. *Id.*

143. *Id.*

144. *Id.*

145. Rushforth, *supra* note 16, at 36.

146. *Id.* at 36-37.

147. *Id.* at 37.

148. *Id.*

149. *Id.*

150. Rushforth, *supra* note 16, at 37.

psychiatric beds at all.¹⁵¹ Consequently, across the state, the critical shortage of state psychiatric beds is forcing mentally ill individuals in desperate need of treatment to be held in emergency rooms and jails until beds become vacant.¹⁵²

III. ISSUE

“He needs hospitalization and custodial care, but we can’t seem to get any help for him without violating his civil rights. It is very painful for us all.”¹⁵³

This statement was made by the father of a Stanford University graduate diagnosed with schizophrenia.¹⁵⁴ As a result of the son’s crippling disease, he soon became a member of San Francisco’s growing homeless population.¹⁵⁵ Another tragic casualty of deinstitutionalization, Larry Hogue, or better known as “The Wild Man of West 96th Street,” set public fires, broke neighbors’ windows, and exposed himself on the streets of New York as a result of his untreated bipolar disorder.¹⁵⁶ Larry’s disorderly behavior continued for over a decade because state commitment laws kept him from involuntary hospitalization.¹⁵⁷

California has generally maintained a reputation for progressive policy, and in recent years, California has been at the forefront of social change. Yet among the long list of progressive wins in California, reforms in mental health policy constitute a slim portion. For the past sixty years, states have continued to deinstitutionalize their state-run psychiatric hospitals, and California is no exception.¹⁵⁸ Although scientific and social understandings of mental illness have arisen in the last forty years, substantial impediments to effective treatment remain.

While the movement was well-intentioned, deinstitutionalization has been termed a “disaster” and a “tragedy.”¹⁵⁹ One such critic, Dr. E. Fuller Torrey, termed the movement’s results as “a psychiatric Titanic”

151. Jenny Gold, *A Dearth of Psychiatric Hospital Beds for California Patients in Crisis*, NAT’L PUB. RADIO (Apr. 14, 2016), <https://www.npr.org/sections/health-shots/2016/04/14/474210027/a-dearth-of-psychiatric-hospital-beds-for-california-patients-in-crisis>.

152. Ollove, *supra* note 122.

153. TORREY, *AMERICAN PSYCHOSIS*, *supra* note 113, at 108.

154. *Id.*

155. *Id.*

156. *Id.*

157. TORREY, *AMERICAN PSYCHOSIS*, *supra* note 113, at 108.

158. Torrey, *Thirty Years of Shame*, *supra* note 49, at 11; Rhoden, *supra* note 48, at 378; *see* Kofman, *supra* note 4, at 46.

159. Bagenstos, *supra* note 47, at 1.

and “one of the great social disasters of recent American history.”¹⁶⁰ While new welfare programs and legislative structures allowed for the discharge of mentally ill patients from state hospitals, the community treatment centers at which they were to obtain substitute services did not follow.¹⁶¹ Although deinstitutionalization released mentally ill people from “impersonal human warehouses,” the community to which many patients were released had neither the capacity nor the ability to provide adequate mental health care.¹⁶² Patients were thrown out of state psychiatric facilities with nothing more than a prescription for tranquilizing drugs and the clothes on their backs.¹⁶³ Consequently, after released patients failed to meet community standards, they once again became the neglected.¹⁶⁴ However, this time, patients no longer could fall back on the stability of hospital care.

With over fifty years of bad policy comes a multitude of consequences—consequences that include an increasing:

number of mentally ill individuals in hospital emergency rooms waiting for psychiatric beds; demand on police and sheriffs, for all intents and purposes, become frontline mental health workers; number of mentally ill individuals in jails and prisons; number of acts of violence, including homicides, committed by mentally ill individuals who are not being treated; and number of mentally ill homeless individuals.¹⁶⁵

In the years following the deinstitutionalization movement, California witnessed not only an increase in homelessness but also an increase in incarceration and episodes of violence.¹⁶⁶ It has been suggested that the deinstitutionalization movement played a prominent role in this ever increasing trend.¹⁶⁷ Yet despite this fact, California’s state mental hospitals continue to empty, and once again the mentally ill are community pariahs.¹⁶⁸ Today, the streets and prisons have become the new California asylums, and current research indicates that the deinstitutionalization movement is to blame.

160. *Id.*

161. See Ralph Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 649-55 (2003).

162. Rhoden, *supra* note 48, at 387, 410.

163. *Id.*

164. *Id.*

165. NO ROOM AT THE INN, *supra* note 90, at 11.

166. TORREY, AMERICAN PSYCHOSIS, *supra* note 113, at 109.

167. See *id.* at 110.

168. NO ROOM AT THE INN, *supra* note 90, at 22.

IV. ANALYSIS: HOW CALIFORNIA'S DEINSTITUTIONALIZATION MOVEMENT CAUSED AN EPIDEMIC OF HOMELESSNESS AND INCARCERATION

Two of the most notable and persuasive consequences of California's deinstitutionalization movement are the increase in homeless and prison populations. Unfortunately, deinstitutionalization was destined for failure. For starters, only eight-hundred of the intended two-thousand community mental health centers were built.¹⁶⁹ Additionally, most community centers provided zero in-patient services and only a few provided emergency services.¹⁷⁰ Moreover, from 1968 to 1978, only five percent of the admitted patients to these community health centers were individuals released from state mental hospitals.¹⁷¹ Given deinstitutionalization's fundamental flaws, it is no surprise that many mentally ill individuals ended up on the streets or in local prisons as a result of this massive miscarriage of public policy.

In the 1980s, the deinstitutionalization movement increased the proportion of mental illness within homeless and penitentiary populations, and today's lack of mental health services and reforms have kept these individuals on the streets and in prisons. It is evident that serious change needs to happen in mental health policy. Without reform, the demographics of the homeless and incarcerated will continue to resemble a nineteenth century society.

A. Increases in Homelessness

"Homelessness is a symbol of that part of the deinstitutionalization process which failed."¹⁷² California was the first state to feel the repercussions of deinstitutionalization through an increase in homelessness, and by the late 1980s, the entire United States felt the aftermath of the movement.¹⁷³ With the closure of state psychiatric hospitals and the heightened restrictions on civil commitment, mentally ill individuals had very little recourse for treatment and nowhere to go

169. Robert Weisberg, *The Practice of Restorative Justice: Restorative Justice and the Danger of "Community,"* 2003 UTAH L. REV. 343, 364 (2003).

170. E. FULLER TORREY, NOWHERE TO GO: THE TRAGIC ODYSSEY OF THE HOMELESS MENTALLY ILL 147-48 (1988).

171. Baum & Burnes, *supra* note 108, at 164.

172. MICHAEL J. DEAR & JENNIFER R. WOLCH, LANDSCAPERS OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS 195 (1987).

173. TORREY, AMERICAN PSYCHOSIS, *supra* note 113, at 100; Kofman, *supra* note 4, at 33; E. Fuller Torrey, *Ronald Reagan's Shameful Legacy: Violence, the Homeless, Mental Illness*, SALON (Sept. 29, 2013), https://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness/.

except the streets.¹⁷⁴ As early as 1985, Los Angeles estimated that thirty to fifty percent of its homeless were chronically mentally ill and the homeless mentally ill were seen in ever increasing numbers.¹⁷⁵

In a 1988 survey by the National Institute of Mental Health, researchers attempted to document the living arrangements of discharged patients living with chronic mental illness.¹⁷⁶ Results indicated that approximately 120,000 remained hospitalized; 381,000 were in nursing homes; between 175,000 and 300,000 were living in board and care homes; and between 125,000 and 300,000 were thought to be homeless.¹⁷⁷ Therefore, as early as 1988, the United States homeless population increased between 125,000 to 300,000.

This increase can only be attributed to the deinstitutionalization movement, which failed to provide the adequate treatment and care facilities necessary for releasing mentally ill patients back into the community. The community mental health centers were small in number and underfunded,¹⁷⁸ and federal welfare programs provided inadequate financial support.¹⁷⁹ Consequently, discharged individuals not fortunate enough to receive care from family, the government, or community mental health centers often faced serious difficulties readjusting to an independent lifestyle.¹⁸⁰

Additionally, deinstitutionalization posed significant personal challenges for released patients. For example, individuals have to “resurrect forgotten or dormant skills,” find “new friends, a new home, a new job,” and become accustomed to a lack of “support-services.”¹⁸¹ It is no surprise that many mentally ill individuals could not meet the demands of community reintegration. Many individuals relapsed back into psychosis because a majority of discharged patients failed to receive follow-up psychiatric care.¹⁸² Consequently, formerly institutionalized individuals without adequate resources who were unable to live independently were kicked to the streets, making up the growing homeless population across United States.¹⁸³ From 1991 to 1993

174. Rushforth, *supra* note 16, at 33.

175. TORREY, *AMERICAN PSYCHOSIS*, *supra* note 113, at 102.

176. *Id.* at 100.

177. *Id.*

178. Rhoden, *supra* note 48, at 392.

179. *Id.* at 392-93.

180. Kofman, *supra* note 4, at 29; Rhoden, *supra* note 48, at 390-91.

181. DEAR & WOLCH, *supra* note 172, at 20.

182. Rhoden, *supra* note 48, at 392.

183. *Id.* at 390; Kofman, *supra* note 4, at 29.

individuals who possessed chronic mental illness were ten to twenty times more likely than the general public to be homeless.¹⁸⁴

As mental health beds and in-patient centers continue to decrease, more individuals become untreated or undertreated for their mental illnesses. In 2006, researcher F.E. Markowitz conducted a study looking at the relationship between the number of psychiatric hospital beds and the increases in crime and homelessness.¹⁸⁵ His results revealed that as hospital bed numbers decreased, the number of mentally ill homeless increased, along with crimes and arrests associated with homelessness.¹⁸⁶ This study reveals the devastating repercussions of deinstitutionalization and an underfunded mental health care system. Although California may provide funding for psychiatric medications and out-patient appointments, the underfunding of actual in-patient services and beds is a cause of homelessness.

Today, individuals with chronic mental health problems comprise one-third of the homeless population in the United States.¹⁸⁷ The proportion of mentally ill individuals within homeless populations are approximated at one-third of all males and two-thirds of all females.¹⁸⁸ In 1998, San Francisco's homeless population had increased to 16,000 of which an estimated thirty-seven percent were thought to be mentally ill.¹⁸⁹ The mayor of San Francisco, Willie Brown, called this epidemic a "cancer on [the] city's soul."¹⁹⁰ Today, approximately fifty-five percent of homeless individuals in San Francisco experience emotional or psychiatric conditions.¹⁹¹ Thus, it is evident that our homeless population is becoming increasingly mentally ill, and the "cancer" is spreading.

Homelessness emerged as an unintended result of California's deinstitutionalization movement. California closed its state mental hospitals without providing adequate replacement treatment for the

184. E. Susser, E. Valencia, S. Conover, A. Felix, W. Tsai & R. Wyatt, *Preventing Recurrent Homelessness Among Mentally Ill Men: A "Critical Time" Intervention After Discharge from a Shelter*, 87(2) AM. J. PUB. HEALTH 256-57 (1997).

185. See Fred E. Markowitz, *Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates*, 44 CRIMINOLOGY 45-72 (2006).

186. *Id.* at 56-60.

187. TREATMENT ADVOC. CTR., SERIOUS MENTAL ILLNESS AND HOMELESSNESS 1 (2016), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-and-homelessness.pdf> [hereinafter SERIOUS MENTAL ILLNESS & HOMELESSNESS].

188. NO ROOM AT THE INN, *supra* note 90, at 15.

189. TORREY, AMERICAN PSYCHOSIS, *supra* note 113, at 108.

190. *Id.* (citing B. Mandel, *The Homeless Are a Cancer on City's Soul*, SAN FRANCISCO EXAM'R (Jan. 14, 1990)).

191. Jessica Placzek, *Did the Emptying of Mental Hospitals Contribute to Homelessness?*, KQED (Dec. 8, 2016), <https://www2.kqed.org/news/2016/12/08/did-the-emptying-of-mental-hospitals-contribute-to-homelessness-here/>.

mentally ill, and those incapable of community reintegration slowly filled the city streets and the soup kitchen lines.¹⁹² As a result of deinstitutionalization, thousands of mentally ill individuals ended up homeless and incapable of living independently, and today, thousands of individuals remain on the streets due to untreated mental illnesses.¹⁹³ Although the repercussions of an underfunded and undertreated mental healthcare system are increasingly clear, California has made little progress in providing adequate in-patient and out-patient services to both the general and homeless populations.

B. Transinstitutionalization: Incarceration of the Mentally Ill

In the mid-1800s, activists of mental health reform fought for the establishment of state psychiatric hospitals in an effort to remove mentally ill individuals from local prisons and jails. Ironically, today, American jails are termed “the new asylums” due to the persuasiveness of chronic mental illness amongst incarcerated individuals.¹⁹⁴ Transinstitutionalization refers to the transfer of mentally ill individuals from state mental hospitals to other institutions such as prisons.¹⁹⁵ This was ultimately a consequence of the deinstitutionalization movement.¹⁹⁶ Given the rise in mentally ill individuals living amongst their communities, it is no surprise that the criminal justice system also felt serious repercussions from deinstitutionalization.

With the closure of state psychiatric hospitals and the restrictions on civil commitments under the 1967 Lanterman-Petris-Short Act, many individuals had nowhere to go except the streets.¹⁹⁷ Consequently, the prosecution of the mentally ill began. By the early 1970s, it became increasingly apparent that the closure of state mental hospitals had resulted in a discernible increase in the incarceration of the mentally ill. In a 1972 study of San Mateo County, researcher Marc Abramson found

192. See LeRoy L. Kondo & Dale Ross, *Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE U. L. REV. 373, 387-88 (2000); E. Fuller Torrey, *Ronald Reagan's Shameful Legacy: Violence, the Homeless, Mental Illness*, SALON (Sept. 29, 2013), https://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness/.

193. See Kondo & Ross, *supra* note 192, at 387-88; Rhoden, *supra* note 48, at 390-91.

194. TREATMENT ADVOC. CTR., SERIOUS MENTAL ILLNESS PREVALENCE IN JAILS AND PRISONS, HOMELESSNESS 1 (2016), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf>.

195. Andrea Reynoso, *Is California Committed?: Why California Should Take Action to Address the Shortcomings of its Assisted Outpatient Commitment Statute*, 88 S. CAL L. REV. 1021, 1023 (2015).

196. Harcourt, *supra* note 13, at 87.

197. Rushforth, *supra* note 16, at 34.

a thirty-six percent increase in mentally ill prisoners and a one-hundred percent increase in commitments of individuals not competent to stand trial.¹⁹⁸ Specifically, Abramson found an increase in arrests of the mentally ill for crimes such as public intoxication, disorderly conduct, and possession of illegal substances.¹⁹⁹ Abramson noted that many of these arrests were associated with untreated individuals and their subsequent “self-medication” through drugs and alcohol.²⁰⁰ Thus, a lack of treatment soon became a prison sentence for many mentally ill individuals.

Following Abramson’s study, similar observations were made across California in the years following the passage of the Lanterman-Petris-Short Act. Thus, this was not an isolated phenomenon unique to San Mateo County—rather, it indicated a state-wide epidemic. In a study of 301 patients released from Napa State Hospital between 1972 and 1975, researchers reported that forty-one percent of the patients had been arrested and the majority of these patients received no aftercare.²⁰¹ In a 1973 study of Santa Clara County’s jail population, the reports indicated that incarceration rates rose three-hundred percent in the four years following the closure of Agnews State Psychiatric Hospital, which was located in Santa Clara County.²⁰² In 1975, five California jails reported that the number of chronically ill inmates rose three-hundred percent in the last ten years²⁰³ and 6.7 percent of the inmates were severely mentally ill.²⁰⁴ One prison psychiatrist stated,

We are literally drowning in patients, running around trying to put our fingers in the bursting dikes, while hundreds of men continue to deteriorate psychiatrically before our eyes into serious psychoses The crisis stems from recent changes in the mental health laws allowing more mentally sick patients to be shifted away from the mental health department into the department of corrections Many more men are being sent to prison who have serious mental problems.²⁰⁵

198. E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb & James Pavle, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, TREATMENT ADVOC. CTR. 2 (May 2010), https://www.cdcr.ca.gov/Regulations/Adult_Operations/docs/NCDR/2014NCR/14-07/More%20Mentally%20Ill%20Persons%20in%20Jails%20and%20Prisons%20than%20Hospitals.pdf [hereinafter *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals*].

199. Rushforth, *supra* note 16, at 34.

200. *Id.*

201. TORREY, *AMERICAN PSYCHOSIS*, *supra* note 113, at 98.

202. PBS, *supra* note 14.

203. *Id.*

204. *Id.*

205. *Id.*

Thus, with the closure of state mental hospitals, communities across California soon faced an increase in both mentally ill offenders and crime. The growth of mental illness in prisons and jails can be attributed to a variety of factors including: lack of the public mental health funding and treatment, the tightening legislation on drug-related crimes, and the incarceration of the homeless for petty crimes.²⁰⁶

First, in regards to the lack of public mental health funding, many individuals relapsed back into psychosis because a majority of discharged patients failed to receive follow-up psychiatric care.²⁰⁷ Consequently, the untreated individuals were more prone to committing crimes.²⁰⁸ For example, in the 1980s, increasing episodes of violence committed by untreated mentally ill individuals arose across the country.²⁰⁹ Looking specifically to California, a 1988 study of Contra Costa County indicated that seven of the seventy-one homicides in the county were committed by untreated individuals with schizophrenia.²¹⁰ Thus, when inadequate funding is provided to mental health services, crime increases amongst the mentally ill populations.

Likewise, as laws turned more conservative, alcohol- and drug-related charges amongst mentally ill individuals increased, because substance abuse and self-medication occur frequently as a secondary problem to mental illness.²¹¹ Without adequate treatment, many individuals alleviate their symptoms through drug and alcohol consumption.²¹² Thus, due to deinstitutionalization's fundamental flaws, untreated mental illness created a propensity for alcohol and drug abuse, which led to increased drug and alcohol-related crime.

Additionally, the criminalization of homelessness also fueled the significant increases of incarcerated mentally ill. "A 1985 study of Los Angeles of 232 people living in shelters and on the streets who had previously been psychiatrically hospitalized found that seventy six percent of them had been arrested as adults."²¹³ As current law stands, an individual may be convicted of crimes such as urinating in public, sleeping in public places, loitering, or panhandling in front of convenience stores.²¹⁴ These statutes target homeless populations. Consequently, homelessness and imprisonment increase the risk of each

206. Cooper, *supra* note 133, at 344.

207. Torrey, *supra* note 102.

208. TORREY, AMERICAN PSYCHOSIS, *supra* note 113, at 110.

209. *Id.* at 105.

210. *Id.*

211. Cooper, *supra* note 133, at 344.

212. *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals*, *supra* note 198.

213. PBS, *supra* note 14.

214. Cooper, *supra* note 133, at 344.

other. In a 2008 study of American prisons, researchers found recent homelessness to be eight to eleven times more prevalent in jail inmates; the heightened risk was credited in part to mental illness.²¹⁵ Although this study is not specific to California, it still highlights the interconnection between homelessness, incarceration, and mental illness. Ultimately, mentally ill individuals are often imprisoned in a revolving door of crime, punishment, release, homelessness, and re-imprisonment.

Moreover, law enforcement act as “street corner psychiatrists” by arresting mentally ill individuals through “mercy bookings.”²¹⁶ For example, a Los Angeles police captain stated,

You arrest somebody for a crime because you know at least they’ll be put in some kind of facility where they’ll get food and shelter. You don’t invent a crime, but it’s a discretionary decision. You might not arrest everybody for it, but you know that way they’ll be safe and fed.²¹⁷

Often times, state statutes and procedures make it less burdensome for mentally ill individuals to be arrested than to receive emergency psychiatric services.²¹⁸ Consequently, officers who are trying to protect the mentally ill from victimization or poor environmental conditions will often arrest and jail them for their own protection.²¹⁹

Along with an increased incarceration rate, the United States also saw an increase in violent crimes committed by mentally ill individuals.²²⁰ When receiving treatment, mentally ill individuals do not have a higher incidence of violent behavior.²²¹ However, when treatment is not afforded, a number of studies have found that violent behavior heightens.²²² For example, in a study of Contra Costa County, California, records revealed that ten percent of homicides were committed by individuals diagnosed with schizophrenia.²²³ Additionally, in a study conducted of eighty-one American cities, research indicated that as the number of public psychiatric beds decreased, the frequency of violent crime increased.²²⁴ Therefore, it is

215. SERIOUS MENTAL ILLNESS AND HOMELESSNESS, *supra* note 187, at 4.

216. Kondo & Ross, *supra* note 192, at 428; PBS, *supra* note 14.

217. PBS, *supra* note 14.

218. Kondo & Ross, *supra* note 192, at 428.

219. PBS, *supra* note 14.

220. NO ROOM AT THE INN, *supra* note 90, at 14.

221. *Id.*

222. *Id.*

223. *Id.*

224. NO ROOM AT THE INN, *supra* note 90, at 15.

clear that adverse consequences follow as state psychiatric beds are closed.²²⁵

Although the act of incarcerating mentally ill individuals was found improper by the middle of the nineteenth century, today's prisons and jails have re-adopted this archaic practice. Subsequently, this massive incarceration of the mentally ill has led to a number of problems and repercussions including:

[J]ail/prison overcrowding resulting from mentally ill prisoners remaining behind bar longer than other prisoners; behavioral issues disturbing to other prisoners and correctional staff; physical attacks on correction staff and other prisoners; victimization of prisoners with mental illness in disproportionate numbers; deterioration in the psychiatric condition of inmates with mental illness as they go without treatment; relegation in grossly disproportionate numbers to solitary confinement, which worsens the systems of mental illness; jail/prison suicides in disproportionate numbers; increased taxpayer costs; and disproportionate rates of recidivism.²²⁶

Thus, along with increased populations, American prisons face a multitude of secondary consequences when incarcerating the mentally ill.

Over the past forty years, the American prison system has become increasingly overpopulated by the mentally ill.²²⁷ From 1991 to 2001, San Francisco prison officials found that mental health treatment needs increased by seventy-seven percent.²²⁸ In 2005, Los Angeles Sheriff Lee Baca said: "I run the biggest mental hospital in the country."²²⁹ "In fact, the Los Angeles County Jail holds more mentally ill inmates than any remaining psychiatric hospital in the United States."²³⁰ Overall in the United States, "approximately 20% of inmates and 15% of inmates in state prisons are now estimated to have serious mental illness."²³¹ In California, approximately sixteen percent of prison inmates are diagnosed with a serious mental illness.²³² "The number of seriously mentally ill inmates in California's prisons is approximately 364% of the expected incidence in the general population."²³³

225. *Id.*

226. TREATMENT ADVOC. CTR., *supra* note 10, at 7.

227. *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals*, *supra* note 198.

228. *Id.* at 4.

229. *Id.*

230. Rushforth, *supra* note 16, at 35.

231. *Id.*

232. *Id.*

233. *Id.*

I have seen individuals who are living out the rest of their lives behind bars because they committed crimes that probably would not have been committed had they received mental health treatment. I have seen the effect of prison on the mentally ill and the effect of the mentally ill on prison.²³⁴

Transinstitutionalization arose as an unintended result of California's deinstitutionalization movement. Without proper treatment centers, many discharged patients succumbed to their chronic mental illness. Consequently, the prisons and local jails filled with mentally ill inmates, and the revolving-door of crime cycled. Although American prisons are disproportionately filled with mental illness, laws have not changed and treatment is still vastly underprovided.

V. PROPOSAL

"The consequences of not treating the mentally ill are obvious and tragic: homelessness, drug addiction, domestic violence, crime, teenage dropouts, child abuse and neglect."²³⁵

The ultimate solution is to maintain a functioning public psychiatric system that keeps mentally ill individuals from prisons and streets. "Inherent in this intersection of law and mental health is the delicate balance between preserving liberty and autonomy interest on the one hand, and providing for individual and societal safety on the other."²³⁶ By providing proper mental health services, the mentally ill could be afforded a stable life whether within their community or in a state hospital. Two proposals that would help provide a solution to America's mental health crisis include the funding of in-patient services under Proposition 63 and the creation of more mental health courts.

A. Amendment to Proposition 63: Funding for More In-Patient Services

Beginning in the early 1990s, California moved away from a public mental health system and towards a community integrated system. One major win for mental health reform in California was the passage of Proposition 63, "California's Mental Health Services Act" (MHSA), in 2004.²³⁷ Proposition 63 provides funding and support to California's largely broken mental health care system.²³⁸ More specifically, MHSA

234. Kondo & Ross, *supra* note 192, at 429.

235. Kofman, *supra* note 4, at 56.

236. Reynoso, *supra* note 195, at 1021.

237. Andrew M. Holmes, *Initiative Funding Through Targeted Taxes: Proposition 63, Mental Health, and the Crossroads of Direct Democracy*, 59 HASTINGS L.J. 195 (2007).

238. *Id.* at 196.

“increase[s] funding, personnel and other resources to support county mental health programs.”²³⁹ The proposition was enacted “to reduce the long term adverse impact on individuals, families and state and local budgets resulting from untreated mental illness.”²⁴⁰ Essentially, a one percent income tax has been imposed upon individuals with a personal income of one million dollars or more.²⁴¹

One preventative solution to the mental health crisis in America is to amend Proposition 63’s funding scheme to provide more funds towards in-patient services. More specifically, increased funds should be allocated towards the maintenance and creation of more psychiatric hospital beds. With the recommendation to increase in-patient services comes concerns regarding patient autonomy. However, as current policy stands, mentally ill individuals who need and want intensive psychiatric care cannot even obtain a bed in the state mental hospitals.

Without reliable inpatient care, patients are forced into emergency rooms, or worse, remain untreated. By creating more state psychiatric hospital beds, the subsequent results include reduced emergency room boarding, mercy bookings, and the expensive price tag that follows. The long term effects of increasing in-patient mental health services would greatly benefit the entire State. Additionally, for reasons explained below, Proposition 63 should also fund California mental health courts.

B. Mental Health and Drug Courts

The establishment of mental health courts could serve as a partial solution to the “revolving door” mentally ill offender. In the 1980s, the United States instituted a nationwide program known as the “War on Drugs” to deal with America’s growing drug problem.²⁴² As drug laws tightened, the criminal justice system formed specialty courts known as drug courts to provide treatment rather than punishment to drug users.²⁴³ With the implementation of drug courts, states have seen a reduction in financial and societal costs associated with the incarceration of drug-related offenders.²⁴⁴ Thus, the creation of state mental health courts would likely provide similar results.

239. *Mental Health Services Act*, CAL. DEP’T OF HEALTH CARE SERVS. (Jan. 29 2018), http://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx.

240. 2004 Cal. Legis. Serv. A-47 § 3(b) (West).

241. *Mental Health Services Act*, *supra* note 239.

242. Barbara E. Smith, Robert C. Davis & Arthur J. Lurigio, *Introduction to the Special Issue*, 17 JUST. SYS. J. v (1994); *War on Drugs*, HISTORY (Aug. 21 2018), <https://www.history.com/topics/crime/the-war-on-drugs>.

243. John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 923-24 (2000).

244. Kondo & Ross, *supra* note 192, at 400.

Like drug courts, a mental health court system could facilitate treatment and rehabilitation rather than a traditional adversarial approach.²⁴⁵ The system seeks to provide long term solutions through cooperation and communication between the defendant, judge, law enforcement, and treatment providers.²⁴⁶ By establishing mental health courts, judges become more familiarized with mental illness and can provide appropriate services. Consequently, mentally ill defendants are diagnosed, treated, and rehabilitated rather than locked away amongst the growing prison population.

Additionally, local communities who currently run mental health courts have seen tremendous success. For example, in Santa Clara County, Judge Stephen Manley runs the county's drug and mental health court; and his courtroom tells the success story—

The thank-you notes, the crayon drawings from grateful children, and the former defendants who've regained the ability to smile—they are all telltale signs seldom found elsewhere in the local criminal justice system, where drama and sorrow ordinarily drown out the kind of hope Manley sells inside his courtroom every day.²⁴⁷

Judge Manley's court focuses on rehabilitating defendants rather than subjecting them to a cycle of incarceration.²⁴⁸ Manley has "graduated" hundreds of mentally ill convicts who have successfully turned their lives around through drug and mental health treatment.²⁴⁹ Today, over California has over forty mental health courts due to their long-term cost effectiveness.²⁵⁰ In a 2007 study of San Francisco's mental health courts, the data showed a reduced crime rate amongst mentally ill offenders.²⁵¹ Although still early in their inception, mental health courts are already positively affecting California's criminal justice system.

The greatest barrier to establishing mental health courts is obtaining adequate financial and political support for such programs.²⁵² "[S]tate

245. *Id.* at 411.

246. *Id.* at 412.

247. Howard Mintiz, *San Jose Judge Runs Unique Courts for Drug-Addicted and Mentally Ill*, MERCURY NEWS (Dec. 28, 2008), <https://www.mercurynews.com/2008/12/28/san-jose-judge-runs-unique-courts-for-drug-addicted-and-mentally-ill/>.

248. *Id.*

249. *See id.*

250. *Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report*, ADMIN. OFFICE OF THE COURTS: JUDICIAL COUNSEL OF CALIFORNIA 70, 72 (Apr. 2011), https://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf.

251. Cooper, *supra* note 133, at 359.

252. *See* Kondo & Ross, *supra* note 192, at 423.

legislators, policy-makers, and citizens hold the purse strings to authorize and permit creation of these specialty courts.”²⁵³ Given that policy makers and voters ultimately decide whether to finance these specialty courts, they hold the capability for establishing these courts in their local criminal justice systems.²⁵⁴ Additionally, ensuring that sufficient mental health resources are available to these mental health courts also poses a significant hurdle.²⁵⁵ Although mental health court judges may order mental health treatment, state hospitals and local treatment centers may turn away patients due to overcrowding.²⁵⁶ Therefore, amendments to Proposition 63 would also tremendously help support mental health courts as well. Thus, the combination of increased mental health funding through Proposition 63 and the establishment of mental health courts would positively impact the mental health crisis in California and United States.

VI. CONCLUSION

The mentally ill make up our communities, our friends, and even our families, and despite this fact, advancements in mental health policy have dwindled. After years of faulty regulation, both the United States and California have felt the consequences of not only the deinstitutionalization movement but also the consequences of inadequate mental health care. Mental illness is not a death sentence or an ultimatum. Mental illness can be treated and managed. Yet today, our society's streets and prisons are filled with the mentally ill because of inadequate psychiatric treatment. Consequently, for some, mental illness becomes a sentence to life in prison or life on the streets.

The United States and California must enact changes both in the distribution of mental health funds and in the structure of the criminal justice system. By providing adequate funds for in-patient services, mentally ill individuals can seek the treatment they so desperately need—the treatment that will keep them off the streets and out of our prisons. Additionally, by establishing mental health courts, mentally ill defendants can obtain treatment and rehabilitation rather than an adversarial punishment. Mental illness currently fills the pages of our court dockets and fills the lines of our local soup kitchens, but it does not have to. Rather, by providing adequate change in our mental health policy and treatment, mental illness can fill the desks of our universities and run the lines of our local businesses.

253. *Id.*

254. *Id.* at 422.

255. *Id.* at 423.

256. *Id.* at 418-19.