DEINSTITUTIONALIZATION: A PSYCHIATRIC TITANIC

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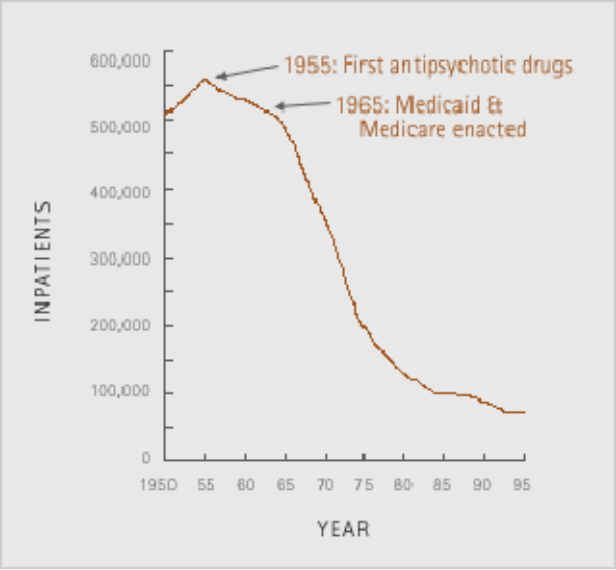
Deinstitutionalization is the name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions; it has been a major contributing factor to the mental illness crisis. (The term also describes a similar process for mentally retarded people, but the focus of this book is exclusively on severe mental illnesses.)

Deinstitutionalization began in 1955 with the widespread introduction of chlorpromazine, commonly known as Thorazine, the first effective antipsychotic medication, and received a major impetus 10 years later with the enactment of federal Medicaid and Medicare. Deinstitutionalization has two parts: the moving of the severely mentally ill out of the state institutions, and the closing of part or all of those institutions. The former affects people who are already mentally ill. The latter affects those who become ill after the policy has gone into effect and for the indefinite future because hospital beds have been permanently eliminated.



The magnitude of deinstitutionalization of the severely mentally ill qualifies it as one of the largest social experiments in American history. In 1955, there were 558,239 severely mentally ill patients in the nation's public psychiatric hospitals. In 1994, this number had been reduced by 486,620 patients, to 71,619, as seen in Figure 1.2. It is important to note, however, that the census of 558,239 patients in public psychiatric hospitals in 1955 was in relationship to the nation's total population at the time, which was 164 million.

By 1994, the nation's population had increased to 260 million. If there had been the same proportion of patients per population in public mental hospitals in 1994 as there had been in 1955, the patients would have totaled 885,010. The true magnitude of deinstitutionalization, then, is the difference between 885,010 and 71,619. In effect, approximately 92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994. Even allowing for the approximately 40,000 patients who occupied psychiatric beds in general hospitals or the approximately 10,000 patients who occupied psychiatric beds in community mental health centers (CMHCs) on any given day in 1994, that still means that approximately 763,391 severely mentally ill people (over three-quarters of a million) are living in the community today who would have been hospitalized 40 years ago. That number is more than the population of Baltimore or San Francisco.

Deinstitutionalization varied from state to state. In assessing these differences in census for public mental hospitals, it is not sufficient merely to subtract the 1994 number of patients from the 1955 number, because state populations shifted in the various states during those 40 years. In Iowa, West Virginia, and the District of Columbia, the total populations actually decreased during that period, whereas in California, Florida, and Arizona, the population increased dramatically; and in Nevada, it increased more than sevenfold, from 0.2 million to 1.5 million. The table in the Appendix takes these population changes into account and provides an effective deinstitutionalization rate for each state based on the number of patients hospitalized in 1994 subtracted from the number of patients that would have been expected to be hospitalized in 1994 based on that state's population. It assumes that the ratio of hospitalized patients to population would have remained constant over the 40 years.

Rhode Island, Massachusetts, New Hampshire, Vermont, West Virginia, Arkansas, Wisconsin, and California all have effective deinstitutionalization rates of over 95 percent. Rhode Island's rate is over 98 percent, meaning that for every 100 state residents in public mental hospitals in 1955, fewer than 2 patients are there today. On the other end of the curve, Nevada, Delaware, and the District of Columbia have effective deinstitutionalization rates below 80 percent.

Most of those who were deinstitutionalized from the nation's public psychiatric hospitals were severely mentally ill. Between 50 and 60 percent of them were diagnosed with schizophrenia. Another 10 to 15 percent were diagnosed with manic-depressive illness and

severe depression. An additional 10 to 15 percent were diagnosed with organic brain diseases -- epilepsy, strokes, Alzheimer's disease, and brain damage secondary to trauma. The remaining individuals residing in public psychiatric hospitals had conditions such as mental retardation with psychosis, autism and other psychiatric disorders of childhood, and alcoholism and drug addiction with concurrent brain damage. The fact that most deinstitutionalized people suffer from various forms of brain dysfunction was not as well understood when the policy of deinstitutionalization got under way.

Thus deinstitutionalization has helped create the mental illness crisis by discharging people from public psychiatric hospitals without ensuring that they received the medication and rehabilitation services necessary for them to live successfully in the community. Deinstitutionalization further exacerbated the situation because, once the public psychiatric beds had been closed, they were not available for people who later became mentally ill, and this situation continues up to the present. Consequently, approximately 2.2 million severely mentally ill people do not receive any psychiatric treatment.

Deinstitutionalization was based on the principle that severe mental illness should be treated in the least restrictive setting. As further defined by President Jimmy Carter's Commission on Mental Health, this ideology rested on "the objective of maintaining the greatest degree of freedom, self-determination, autonomy, dignity, and integrity of body, mind, and spirit for the individual while he or she participates in treatment or receives services."[8] This is a laudable goal and for many, perhaps for the majority of those who are deinstitutionalized, it has been at least partially realized.

For a substantial minority, however, deinstitutionalization has been a psychiatric Titanic. Their lives are virtually devoid of "dignity" or "integrity of body, mind, and spirit." "Self-determination" often means merely that the person has a choice of soup kitchens. The "least restrictive setting" frequently turns out to be a cardboard box, a jail cell, or a terror-filled existence plagued by both real and imaginary enemies.

CHAPTER 3: JAILS AND PRISONS

Deinstitutionalization doesn't work. We just switched places. Instead of being in hospitals the people are in jail. The whole system is topsy-turvy and the last person served is the mentally ill person. -- Jail official, Ohio [1]

Confining George Wooten in the Denver County Jail in May 1984 was another indicator of the growing mental illness crisis. The 32-year-old Wooten had been jailed over 100 times, including 28 times in the previous 2 years, for creating disturbances in the community. Wooten had been diagnosed with schizophrenia at age 17, and each time he used alcohol or sniffed glue or paint fumes, it exacerbated his schizophrenia and led to his disorderly behavior.

According to a newspaper account, "Wooten says he likes jailers and the place. He calls it home. … Eight years ago, the officers might have taken Wooten to a community mental health center, a place that was supposed to help the chronically mentally ill. But now they don't bother. … Police have become cynical about the whole approach. They have learned that 'two hours later [those arrested] are back on the street … the circle of sending the person to a mental health center doesn't work.'"[2]

Removing the Mentally Ill from Jails

The odyssey of repeated incarceration for severely ill people like George Wooten was common in the United States in the early 1800s although many Americans found such practices inhumane and uncivilized. Their sentiments found organized expression in the Boston Prison Discipline Society, which was founded in 1825 by the Reverend Louis Dwight, a Yale graduate and Congregationalist minister. Shocked by what he saw when he began taking Bibles to inmates in jails, he established the society to publicly advocate improved prison and jail conditions in general and hospitals for mentally ill prisoners in particular. According to the medical historian, Gerald Grob, Dwight's "insistence that mentally ill persons belonged in hospitals aroused a responsive chord, especially since his investigations demonstrated that large numbers of such persons were confined in degrading circumstances."[3]

Dwight's actions led the Massachusetts legislature to appoint a committee in 1827 to investigate conditions in the state's jails. The committee's report, which was directed to the State General Court, included documentation that many "lunatics and persons furiously mad" were being confined, often in inhumane and degrading conditions. In one jail, a man had been kept for nine years. "He had a wreath of rags around his body and another round his neck. … He had no bed, chair or bench … a heap of filthy straw, like the nest of swine, was in the corner. … The wretched lunatic was indulging [in] some delusive expectations of being soon released from this wretched abode."[4]

The committee report concluded, "The situation of these wretched beings calls very loudly for some redress. They seem to have been considered as out of the protection of laws. Less attention is paid to their cleanliness and comfort than to the wild beasts in their cages, which are kept for show."[5]

Among the specific recommendations of the committee was that all mentally ill inmates of jails and prisons should be transferred to the Massachusetts General Hospital and that confinement of mentally ill persons in the state's jails should be made illegal. Three years later, the Massachusetts General Court "overwhelmingly approved a bill providing for the erection of a state lunatic hospital for 120 patients"; this opened in 1833 as the State Lunatic Asylum at Worcester. When the hospital opened, "more than half of the 164 patients received during that year came from jails, almshouses, and houses of correction [prisons]."[6] One-third of these patients had been confined in these institutions for longer than 10 years.

Dorothea Dix, the most famous and successful psychiatric reformer in American history, picked up where Dwight had left off. In 1841, with the American asylum-building movement under way, Dix began a campaign that would focus national attention on the sad plight of the mentally ill in jails and prisons and would be directly responsible for the opening of at least 30 more state psychiatric hospitals.

At the time she began her crusade, Dix was a 39-year-old teacher who had been left a bequest by her grandmother, allowing her to give up teaching. Her father had been "shiftless, poverty stricken and irresponsible … fanatically religious, with a penchant for writing theological tracts in fits of 'inspiration,'"[7] and her childhood had therefore been very difficult. Her father may in fact have been mentally ill, which would account in part for her zeal to improve conditions for such sufferers.

Dix's crusade began in early 1841, when she agreed to teach a Sunday school class at the East Cambridge Jail outside Boston. While there, she noticed not only that there were insane prisoners among the inmates, but also that the insane prisoners had no heat in their cells. When she inquired about this, she was told by the jailer that it was because "the insane need no heat." Horrified, Dix reported her findings to her friends and set out to investigate other jails in Massachusetts to ascertain whether similar conditions prevailed. Over the next year, she visited dozens of jails and almshouses and then presented a report to the state legislature. It rang of reform and set the tone for Dorothea Dix's future work:

I come to present the strong claims of suffering humanity. I come to place before the Legislature of Massachusetts the condition of the miserable, the desolate, the outcast. I come as the advocate of helpless, forgotten, insane and idiotic men and women … of beings wretched in our prisons, and more wretched in our Alms-Houses.
I proceed, Gentleman, briefly to call your attention to the state of Insane Persons confined within this Commonwealth, in *cages, closets, cellars. stalls, pens: Chained, naked, beaten with rods,* and lashed into obedience![8]

After finishing her report in Massachusetts, Dix moved on to New Jersey, where she proceeded in the same fashion to visit jails and almshouses, then report to the state legislature and urge the building of public psychiatric hospitals in which insane persons could be treated humanely and receive treatment. By 1847, she had taken her crusade to many eastern states and visited 300 county jails, 18 prisons, and 500 almshouses. Her success in persuading state legislatures to build psychiatric hospitals was impressive, and she provided a major impetus to the reform movement.

The Reverend Louis Dwight and Dorothea Dix were remarkably successful in leading the effort to place mentally ill persons in public psychiatric hospitals rather than in jails and almshouses. By 1880, there were 75 public psychiatric hospitals in the United States for the total population of 50 million people. In 1880, the first complete census of "insane persons" in the United States was carried out. It was, in fact, a more complete census than has ever been carried out since and included letters to all physicians asking them to enumerate all "insane persons" in their community, a question about "insanity" on the census form that went to every household, and a canvassing of all hospitals, jails, and almshouses. A total of 91,959 "insane persons" were identified, of which 41,083 were living at home, 40,942 were in "hospitals and asylums for the insane," 9,302 were in almshouses, and only 397 were in jails. The total number of prisoners in all jails and prisons was 58,609, so that severely mentally ill inmates constituted only 0.7 percent of the population of jails and prisons.

That was the situation in 1880.[9]

Putting the Mentally Ill Back into Jails

The mentally ill began reappearing in America's jails and prisons in large numbers approximately 90 years after the 1880 census. In 1974 and 1975, for example, Glenn Swank and Darryl Winer assessed 545 inmates in the Denver County Jail and reported, "The number of psychotic persons encountered in the jail was striking, as was the number with a history of psychiatric hospitalization, particularly long-term (more than one month) or multiple hospitalizations. … Of the jail inmates with a history of long-term psychiatric hospitalization, many had been state mental hospital patients." They also noted a widespread belief among jail personnel

"that there has been a marked increase in the number of severely mentally disturbed individuals entering the jail in recent years, but unfortunately there are no earlier data available for comparison. … The [jail] system seemed to have inherited responsibility for these persons by default rather than preference."[10]

A study of five California county jails carried out in 1975 by Arthur Bolton and Associates found that 6.7 percent of the inmates were severely mentally ill at the time of examination.[11] Gary Whitmer's 1980 study of 500 mentally ill people who had been charged with crimes emphasized the causal relationship between the person's mental illness and his or her crime, and he cited examples such as a man who had "smashed the plate-glass window of a retail store because he saw a dinosaur jumping out at him"; a woman who refused to pay her restaurant bill because she believed that "she was the reincarnation of Jesus Christ"; a man who harassed two other men whom he believed to be "CIA agents who had kidnapped his benefactress"; and a woman with paranoid delusions who went up to a man on the street and "struck the victim in the right buttocks" with a hat pin.[12]At the time of their arrests, only 6 percent of the mentally ill studied by Whitmer were involved in any treatment program, leading him to conclude that the reforms brought about by deinstitutionalization had "forced a large number of those deinstitutionalized patients into the criminal justice system."

By the early 1980s, interest in the problem of the mentally ill in jails and prisons was growing, increasing as their numbers increased, and two methodologically sound studies of the problem were carried out. In Chicago, Linda Teplin, spurred by the observation that "mental health professionals speculate that the jails have become a repository for the severely mentally ill," interviewed 728 jail admissions using a structured psychiatric interview and found that 6.4 percent of them met diagnostic criteria for schizophrenia, mania, or major depression.[13] In Philadelphia, Edward Guy and his colleagues interviewed 96 randomly selected admissions to the jail and reported that 4.6 percent had schizophrenia or manic-depressive illness, which they labeled as "an alarmingly high incidence of mental illness among inmates of a city jail."[14]

A more inclusive but methodologically less rigorous study of mentally ill people in the nation's jails was carried out in 1992 by the Public Citizen Health Research Group and the National Alliance for the Mentally Ill.[15] Questionnaires were mailed to the directors of all 3,353 county and city jails in the United States asking them to estimate the percentage of inmates who on any given day "appeared to have a serious mental illness." This was further defined to include only inmates with schizophrenia or manic-depressive illness who were exhibiting symptoms such as auditory hallucinations, delusions, confused or illogical thinking, bizarre behavior, or marked mood swings. The jail directors were instructed not to include as mentally ill anyone who exhibited "suicidal thoughts or behavior" or "alcohol and drug abuse" unless the person also had other symptoms as previously described. No attempt was made to identify mentally ill inmates with more subtle symptoms of mental illness (e.g., an inmate with paranoid schizophrenia who did not discuss his delusional beliefs); the survey sought to count only those who were the most severely and overtly mentally ill.

Replies were received from 41 percent of the jails, which represented 62 percent of all jail inmates in the United States. Overall, the jail directors estimated that 7.2 percent of inmates appeared to have a serious mental illness, ranging from less than 3 percent in jails in Wyoming, Nevada, Idaho, and South Carolina to almost 11 percent in jails in Connecticut, Hawaii, and Colorado.

Studies of inmates with psychiatric disorders in state prisons have also been carried out, and the results agree with the results from the studies done in jails. In general, jails keep prisoners sentenced for one year or less, whereas prisons keep prisoners with longer sentences. Ron Jemelka and his colleagues reported that many such studies "used a field survey approach in which one or more key administrators in each prison system was asked to respond to a series of questions about the mentally ill in their facilities. These surveys have suggested that 6 to 8 percent of state prison populations have a serious psychiatric illness," but for a variety of reasons "facility surveys are likely to substantially underestimate the number of mentally ill offenders."[16]

When prison inmates have been actually interviewed, a higher percentage have been found to be severely mentally ill. In 1980, Frank James and his associates reported findings from interviews of 246 prisoners in Oklahoma; 10 percent of them were found to be acutely and severely disturbed.[17] In 1987, Henry Steadman and his colleagues published the results of interviews with 3,332 prison inmates in New York State; 8 percent of them were said to have "very substantial psychiatric and functional disabilities that clearly would warrant some type of mental health service."[18]

A 1988 study of 109 new admissions to the Washington State prison system, using a structured diagnostic interview, reported that 8.4 percent had schizophrenia, manic-depressive illness, or mania, while 1.9 percent more had schizophreniform disorder, and 10 percent met diagnostic criteria for depression.[19] A similar study of 1,070 prison inmates in Michigan found that 6.6 percent had schizophrenia or manic-depressive illness and 5.1 percent had major depression.[20] Considering all these studies, Jemelka et al. concluded that 10 to 15 percent of prisoners have a major thought disorder or mood disorder and "need the services usually associated with severe or chronic mental illness."[21]

Other studies have also been used to ascertain how frequently people with severe mental illnesses are put into jails and prisons. In 1991, a telephone survey was carried out of 1,401 randomly selected members of the National Alliance for the Mentally Ill, an advocacy and support group composed mostly of family members of persons with schizophrenia and manic-depressive illness. It was

found that 40 percent of the mentally ill in this group had been arrested at some time in their lives and, at any given time, 1 percent of them were in jail or prison.[22]

Studies have also been done to ascertain arrest and incarceration rates for the homeless who are mentally ill. A 1985 study in Los Angeles of 232 people living in shelters and on the streets who had previously been psychiatrically hospitalized found that 76 percent of them had been arrested as adults.[23] This is similar to the 74 percent previous arrest rate reported for severely mentally ill inmates examined in the Los Angeles County Jail.[24] Such studies demonstrate a large overlap between mentally ill persons who are homeless and those who are in jail.

How many people with severe mental illnesses are in jails and prisons on any given day? If such illnesses are defined to include only schizophrenia, manic-depressive illness, and severe depression, then approximately 10 percent of all jail and prison inmates appear to meet these diagnostic criteria. The most recent data available in 1995 indicated there were 483,717 inmates in jails and 1,104,074 inmates in state and federal prisons in the United States, a total of 1,587,791 prisoners.[25] If 10 percent of them are severely mentally ill, that would be approximately 159,000 people. It is also likely that the mentally ill often rotate back and forth between being homeless and being in jails or prisons. …

The Imprisoned Mentally Ill and Deinstitutionalization

Between 1980 and 1995, the total number of individuals incarcerated in American jails and prisons increased from 501,886 to 1,587,791, an increase of 216 percent. During this time, the general population increased by only 16 percent.[43] The vast majority of this increase has been fueled by changing demographics, more stringent mandatory sentencing laws, and the increasing availability of cocaine and other street drugs. Have the mentally ill, however, contributed more than their expected share to the increasing population of jails and prisons?

Several lines of evidence suggest the answer is yes. First, in 1939, Lionel Penrose, studying the relationship between mental disease and crime in European countries, showed that prison and psychiatric hospital populations were inversely correlated, As one rose, the other fell.[44] This has become known as the balloon theory -- push in one part of a balloon and another part will bulge out. In 1991, George Palermo and his colleagues published an extensive analysis of the balloon theory utilizing data on U.S. mental hospitals, jails, and prisons for the 83 years between 1904 and 1987. They found the theory to be valid and concluded:

The number of the mentally ill in American jails and prisons supports the thesis of progressive transinstitutionalism. The authors believe that the statistical evidence derived from the national census data corroborates their clinical observation that jails have become a repository of pseudooffenders -- the mentally ill. Our opinion is that our results probably refIect the state of most United States jails.[45]

Observations by psychiatrists and by corrections officials also support a causal relationship between deinstitutionalization and the increasing number of former patients in jails and prisons. California was the first state to aggressively undertake deinstitutionalization, implementing the Lanterman-Petris-Short (LPS) Act in 1969, which made it much more difficult to involuntarily hospitalize, or keep in the hospital, persons who are mentally ill. In 1972, Marc Abramson, a psychiatrist in San Mateo County, published data showing that the number of mentally ill persons entering the criminal justice system doubled in the first year after the Lanterman-Petris-Short Act went into effect. Abramson said, "As a result of LPS, mentally disordered persons are being increasingly subjected to arrest and criminal prosecution."[46] Abramson also coined the term "criminalization of mentally disordered behavior" and in a remarkably prophetic statement said, "If the mental health system is forced to release mentally disordered persons into the community prematurely, there will be an increase in pressure for use of the criminal justice system to reinstitutionalize them. Those who castigate institutional psychiatry for its present and past deficiencies may be quite ignorant of what occurs when mentally disordered patients are forced into the criminal justice system."

Similar observations were made throughout California in the years following implementation of the Lanterman-Petris-Short Act. A 1973 study in Santa Clara County indicated the jail population had risen 300 percent in the four years after the closing of Agnews State Psychiatric Hospital, located in the same county.[47] In 1975, a study of five California jails by Arthur Bolton and Associates reported that the number of severely mentally ill prisoners had grown 300 percent over 10 years.[48] In California's prisons, the number of mentally ill inmates also rose sharply in the 1970s. One prison psychiatrist summarized the situation:

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.[49]

A second approach to assessing the relationship between deinstitutionalization and the increasing number of mentally ill people in jail prisons is to examine the reasons for incarceration. In the 1992 Public Citizen survey, investigators found that *29 percent* of the jails sometimes incarcerate persons *who have no charges against them* but are merely waiting for psychiatric evaluation, the availability of a psychiatric hospital bed, or transportation to a psychiatric hospital. Such jailings are done under state laws permitting emergency detentions of individuals suspected of being mentally ill and are especially common in rural states such as Kentucky, Mississippi, Alaska, Montana, Wyoming, and New Mexico.

In Idaho, the incarceration of mentally ill persons who had broken no laws was standard practice until 1991, when the Idaho legislature made it illegal. Any persons requiring involuntary commitment were taken first to the local jail rather than to a hospital emergency room until they could be examined by a state-appointed psychologist. If the psychologist advised hospitalization, these people remained in jail until a psychiatric hospital bed became available. In 1990, Idaho state officials estimated that approximately 300 persons who had not been charged with any crime had been jailed that year for an average of five days each while awaiting psychiatric referral. This practice was true not only for the rural counties but also for Boise, the state capital, where the Ada County jail detained 85 persons without charges even though there were two private hospitals with psychiatric beds a few blocks from the jail. One of them had even been built with a federal Community Mental Health Center construction grant. In many states, especially those with poorly developed public psychiatric services, this practice continues. A sheriff in Florida observed, "I have had mentally ill inmates in paper gowns in holding cells for close observation for up to six weeks before we could find a hospital bed for them."

Most severely mentally ill people in jail are there because they have been charged with a misdemeanor. A 1983 study by Edwin Valdiserri and his associates reported that mentally ill jail inmates were "four times more likely to have been incarcerated for less serious charges such as disorderly conduct and threats" compared with nonmentally ill inmates.[50] These inmates were 3 times more likely than those not mentally ill to have been charged with disorderly conduct, 5 times more likely to have been charged with trespassing, and 10 times more likely to have been charged with harassment. A more recent study at the Mental Health Unit of the King County Correctional Facility in Seattle found that 60 percent of the inmates had been jailed for misdemeanors and had been arrested on the average of six times in the previous three years.[51] Similar findings have been reported from other parts of the United States. In Madison, Wisconsin, the most common charges brought against the mentally ill who end up in jail are "lewd and lascivious behavior (such as urinating on a street corner), defrauding an innkeeper (eating a meal, then not paying for it), disorderly conduct (such as being too loud), menacing panhandling, criminal damage to property, loitering or petty theft."[52]

In examining records of these arrests, researchers often find a direct relationship between the person's mental illness and the behavior that led to apprehension. For example, a woman with schizophrenia in New Mexico was arrested for assault when she entered a department store and began rearranging the shelves because of her delusion that she worked there; when asked to leave, she struck a store manager and a police officer. A man with schizophrenia in Pennsylvania who was behaving bizarrely on the street was arrested for assault after he struck a teenager who was making fun of him. People who suffer from paranoid schizophrenia, in particular, are likely to be arrested for assault because they may mistakenly believe someone is following them or trying to hurt them and will strike out at that person.

Theft may involve anything from cans of soda (an Oregon man with schizophrenia was arrested for "stealing pop bottles to turn in for refund") to a yacht (a Kentucky man with manic-depressive illness stole a yacht at a dock, then drove it around the lake until it ran out of gas). One of the most common forms of theft involves going to a restaurant and running out at the end of the meal because the person has no money, a practice commonly referred to as "dine and dash."

Police frequently use disorderly conduct charges to arrest a mentally ill person when no other charge is available. The mother of a son with schizophrenia in Texas said that her son was frequently arrested for "just wanting to talk to normal (his word) people in the malls or street. … He would follow them and just keep talking. … [He] would not go away when they asked him to and they were afraid. … His looks were very unkempt, which added to their fear." A man with manic-depressive illness in Washington State remembers being arrested for disorderly conduct because "I played music on my stereo too loud" and his neighbors complained. A man with schizophrenia in Illinois was arrested for throwing a television set out the window, probably because he believed it was talking to him.

Alcohol- and drug-related charges are also common because alcohol and drug use among this population frequently occurs as a secondary problem among the mentally ill (e.g., a woman with manic-depressive illness in Califomia was arrested for being drunk and disorderly on the street). There have been numerous arrests for driving while under the influence of alcohol or drugs; in some cases the person has not used either but, because of bizarre behavior, is assumed to have done so by the arresting officer.

Trespassing is another catchall charge police officers often use to remove mentally ill persons from the street. A man with schizophrenia and alcohol abuse in New Hampshire has been arrested 26 times, mostly on trespassing charges. A woman in Tennessee reported that her son with schizophrenia had been arrested and put in jail for holding a sign that says "Will Work For Food" and on another occasion for sleeping in a cemetery. In another scenario that frequently leads to arrest for trespassing, the mentally ill person

has a delusion of owning a building; a man in Florida was arrested for refusing to leave a motel "that God had given him," and a man in Kansas entered a farmhouse and went to sleep because he believed he had won the farm as a prize from a cigarette company.

Local businesses often exert pressure on the police to get rid of "undesirables," including the mentally ill. This is especially true in tourist towns such as New Orleans, where the police have a well-known reputation for "cleaning the streets" by arresting all vagrants and homeless persons. A police official in Atlanta described how mentally ill homeless persons at the city's airport are routinely arrested, while a sheriff in South Carolina confided that "our problems usually stem from complaints from local business operators." "Mercy bookings" by police who are trying to protect the mentally ill are also surprisingly common. This is especially true for women, who are easily victimized, even raped, on the streets. A sheriff in Arizona admitted that police officers "will find something to charge the person with and bring her to jail." A jail official in West Virginia, after describing how the local state psychiatric hospital routinely discharged severely disabled patients to the streets, said, "If the mental institutions will not hold them, *I will*."

In Madison, Wisconsin, police arrested a mentally ill woman who was yelling on the streets and charged her with disorderly conduct. According to a police department spokesperson, "People called us because they were afraid she'd be assaulted ... the woman was not exhibiting the dangerous behavior necessary for commitment to Mendota [State Hospital], she didn't want to go to a shelter and no one could force medication on her."[53] So the police arrested and jailed her for her own protection.

A Los Angeles police captain sounded the same theme:

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.[54]

Another member of the Los Angeles police force described frequent arrests of severely mentally ill homeless persons:

[They are] suffering from malnutrition, with dirt-encrusted skin and hair or bleeding from open wounds. … It's really, really pitiful. … You get people who are hallucinating, who haven't eaten for days. It's a massive cleanup effort. They get shelter, food, you get them back on their medications. … It's crisis intervention.[55]

Sometimes "mercy bookings" are initiated by mentally ill persons themselves to get into jail for shelter or food; a man in Florida admitted, that "I would commit a crime near the police station and turn myself in. … Jail would take me in and put me to work cleaning floors."

The mentally ill also are sometimes jailed because their families find it is the most expedient means of getting the person into needed treatment. As the public psychiatric system in the United States has progressively deteriorated, it has become common practice to give priority for psychiatric service to persons with criminal charges pending against them. Thus, for a family seeking treatment for an family member, having the person arrested may be the most efficient way to accomplish their goal.

This method of getting treatment is also used in states in which psychiatric hospitals are only available for people who are a danger to themselves or others. In the Public Citizen survey of jails, numerous family members confided that either the police or mental health officials had encouraged them in pressing charges against their family members to access psychiatric care for them. In Massachusetts, the mother of a man with schizophrenia wrote:

In our state a patient cannot get into a state hospital, even if willing, without being dangerous to self or others. … Rather than wait for the patient to become so psychotic that disaster occurs, many families bring charges against a patient for making threats or damaging property. We have done this.

Similarly, in suburban Philadelphia, the parents of a severely ill young man who had no insight into his illness, who had refused treatment, and whom psychiatrists refused to commit involuntarily to a hospital because they claimed he was not a danger to himself or others, was finally hospitalized after his parents called the police. The parents obtained a court order barring him from their home and, when he violated the order, had him arrested. The judge, who had suggested to the parents that they use this mechanism to get treatment for their son, then offered the son a choice of staying in jail or going to the hospital.[56] In these cases, jails become a transitional device to obtain psychiatric care from a failed treatment system.

The most direct approach for assessing the relationship between deinstitutionalization and the increasing number of mentally ill persons in jails and prisons is to ascertain how frequently former patients are arrested after discharge from psychiatric hospitals. Studies done prior to the beginning of deinstitutionalization did not find a higher arrest rate than for the general population. Virtually every study done since deinstitutionalization began has found the opposite.

Eight American studies of arrest rates of discharged psychiatric patients, done between 1965 and 1978, were analyzed by Judith Rabkin. "Each study found that arrest or conviction rates of former mental patients equaled or exceeded those of the general population in at least some crime categories when patients were considered as a homogeneous group." Rabkin concluded, "There has been a pronounced relative as well as absolute increase in arrests of mental patients."[57] Especially impressive was Larry Sosowsky's study of arrest rates of patients discharged from California's Napa State Hospital between 1972 and 1975, after the Lanterman-Petris-Short Act had taken effect. Compared with the general population, discharged patients with no previous arrest prior to hospitalization were arrested 2.9 times more frequently. For the category of "crimes against property" (e.g., shoplifting), the discharged patients were arrested 4.3 times more frequently. Discharged patients who had been arrested prior to their psychiatric hospitalization were arrested approximately 8 times more frequently than the general population.[58]

More recent studies have reported similar trends. John Belcher's study of 132 patients discharged from Columbus State Hospital in Ohio during 4 months in 1985 is particularly interesting. The patients were followed up at 1, 3, and 6 months to ascertain what had happened to them. By the end of 6 months, 17 percent of the 132 patients had been arrested. However, only 65 of the 132 discharged patients had diagnoses of schizophrenia, manic-depressive illness, or severe depression, and 21 of these (32 percent) were among those arrested and jailed. According to Belcher, "These 21 respondents were often threatening in their behaviors" and exhibited bizarre behavior "such as walking in the community without clothes and talking to themselves."[59] They also did not take medications needed to control their psychiatric symptoms and frequently abused alcohol or drugs. Significantly, all 21 of these former patients also became homeless during the 6-month follow-up period, again affirming the close connections between severe mental illnesses, homelessness, and incarceration.

It appears, then, that jails and prisons have increasingly become surrogate mental hospitals for many people with severe mental illnesses. In New York, the estimated population of 10,000 mentally ill inmates in the state's prisons "now surpasses [that of] the state's psychiatric hospitals.[60] In Austin, Texas, "the Travis County Jail has admitted so many prisoners with mental disabilities that its psychiatric population rivals that of Austin State Hospital."[61] In the Dallas County Jail, "On any given day you will find about 900 mentally ill and mentally retarded inmates [which] is more than twice the number housed in the nearest state mental hospital."[62] In Seattle "quite unintentionally, the jail has become King County's largest institution for the mentally ill."[63] In the San Diego County Jail, where "14 percent of the men and 25 percent of the women are on psychiatric medications," an assistant sheriff observes that "we've become the bottom-line mental health provider in the county."[64] And the Los Angeles County Jail, where approximately 3,300 of the 21,000 inmates "require mental health services on a daily basis," is now de facto "the largest mental institution in the country."[65]

APPENDIX: THE MAGNITUDE OF DEINSTITUTIONALIZATION

The following table shows the magnitude of deinstitutionalization for 48 states and the District of Columbia. Alaska and Hawaii became states after deinstitutionalization was under way and are therefore not included. Since the total population of the United States increased from 164 million in 1955 to 260 million in 1994 and since the rate of population change varied markedly for different states, 1994 state population figures can be used to calculate the number of patients who theoretically would have been in public mental hospitals in 1994 if the hospitalization rate had been the same as that which existed in 1955. The effective deinstitutionalization rate, then, is the actual number of patients in public mental hospitals in 1994 subtracted from the theoretical number with the difference expressed as a percentage of the theoretical number (for a discussion of this table, see Chapter 1). The importance of looking at population change when assessing the magnitude of deinstitutionalization can be illustrated by looking at Nevada, which is especially anomalous because it actually had more patients in public psychiatric hospitals in 1994 (760) than it had in 1955 (440). Its actual deinstitutionalization rate is therefore plus 72.7 percent. However, because Nevada's total population increased more than sevenfold during the 40-year period, its effective deinstitutionalization rate, based on the population, was minus 71.4 percent.

State	Patients in Public Mental Hostpitals Dec. 31, 1955 *	Patients in Public Mental Hostpitals Dec. 31, 1994 +	Actual Deinstitutialization Rate (percent)	Theoretical Number of Patients in Public Mental Hospitals in 1994, Based on Population Change since 1955 #	Effective Deinstitutionalization Rate (percent)
Rhode Island	3,442	63	98.2	4,156	98.5
New Hampshire	2,733	137	95.0	5,514	97.5
Arkansas	5,086	183	96.4	7,203	97.5
Vermont	1,294	63	95.1	1,975	96.8
Massachusetts	23,178	793	96.6	23,889	96.7
West Virginia	5,619	224	96.0	5,410	95.9
California	37,211	9,814	89.8	91,641	95.8
Wisconsin	14,981	891	94.1	20,680	95.7
Ohio	28,663	1,849	93.5	35,273	94.8
Colorado	5,720	775	86.5	13,470	94.2
Oklahoma	8,014	675	91.6	11,575	94.2
Illinois	37,883	2,845	92.5	47,153	94.0
Idaho	1,221	138	88.7	2,225	93.8
Kentucky	7,700	645	91.6	10,108	93.6
Arizona	1,690	462	72.7	6,947	93.3
Missouri	12,021	1,109	90.8	15,339	92.8
Montana	1,919	196	89.8	2,579	92.4
Connecticut	8,668	958	88.9	12,324	92.2
South Carolina	6,042	830	86.3	10,052	91.7
Texas	16,445	2,930	82.2	34,883	91.6
Washington	7,631	1,330	82.6	15,060	91.2
Indiana	11,151	1,320	88.2	14,706	91.0
Louisiana	8,271	1,091	86.8	12,084	91.0
Florida	8,026	2,766	65.5	29,857	90.7
Oregon	4,886	855	82.5	9,066	90.6
Minnesota	11,449	1,593	86.1	16,469	90.3
Tennessee	7,693	1,142	85.2	11,629	90.2
Iowa	5,336	513	90.4	5,217	90.2
Utah	1,337	326	75.6	3,257	90.0
New York	96,664	11,286	88.3	109,980	89.7
North Dakota	1,993	213	89.3	2,057	89.6
New Mexico	950	209	78.0	1,984	89.5
Nebraska	4,788	599	87.5	5,662	89.4
New Jersey	22,262	3,405	84.7	31,976	89.4
Pennsylvania	40,920	4,787	88.3	45,072	89.4
Maryland	9,273	1,820	80.4	17,236	89.4
Maine	2,996	440	85.3	3,995	89.0
Virginia	11,303	2,540	77.5	20,796	87.8
Michigan	21,798	3,711	83.0	28,415	86.9
North Carolina	9,960	2,703	77.9	16,608	86.7
Georgia	11,701	3,239	72.3	22,663	85.7
Wyoming	655	147	77.6	1,014	85.5
Kansas	4,420	883	80.0	5,393	83.6
Alabama	7,197	1,649	77.1	9,934	83.4
Mississippi	5,295	1,208	77.2	6,837	82.3
South Dakota	1,603	317	80.2	1,749	81.9
Delaware	1,393	539	61.3	2,536	78.7
Washington, DC	7,318	1,148	84.3	5,280	78.3
Nevada	440	760	+72.7	2,658	71.4
Totals	558,239	71,619	82.0	821,586	91.3