The Mentally III in the Eighties

Robert Sommer, Ph.D.[1] and Humphry Osmond, M.D.[2]

PART I: ON THE STREETS

In 1955 there were 550,000 patients in state mental hospitals. Today that number has shrunk to under 180,000. It is difficult to make a firm count since many former state hospital beds are now occupied by the mentally retarded who had previously been kept in separate institutions. The reduction did not result from the dramatic discovery of a new cure for mental illness. While the tranquilizing drugs made a great improvement in hospital environment, allowing the introduction of social and recreation programs, few would describe their effects as curative. At best they stabilized behavior to the point where it became socially acceptable. The reduction in state hospital population was primarily the result of a de-institutionalization movement which arose as a corrective to the abuse (over-use) of institutional care for the retarded, mentally ill, aged, delinquent, and dependent.

[1] Psychology Department, University of California Davis, California 95616 [2] Bryce Hospital Station 3 Tuscaloosa, Alabama 35401

Resistance to this trend was sparked both by moral and fiscal concerns. It was probably the latter that proved to be the more influential in the long run. The costs of institutional care soared as states were compelled to improve conditions to meet court decisions and the standards set by government agencies and professional organizations. A series of landmark court decisions, such as Wyatt vs. Stickney and O'Connor vs. Donaldson, expanded the rights of hospitalized patients and restricted the criteria for holding them against their will. Legislators were quick to realize that community care was a far less expensive alternative than hospital care.

This combination of fiscal and legal pressures resulted in the massive reduction of state hospital populations. The shrinkage was so dramatic that some states seriously considered shutting down their mental hospitals entirely. Within a 20-year period California had reduced its resident patient population from 35,000 to 5,000. In 1973, then Governor Reagan announced that California was going to get out of the state hospital business. All state hospitals for the mentally ill, except two exclusively for criminal offenders, would be closed by 1977;

hospitals for the retarded would be given an additional four years of grace. The plan provoked strong resistance in the Legislature and eventually the first legislative override of a Reagan veto.

In 1978 a select New Jersey legislative committee attempted to find out what happened to the former mental patients who had been returned to society. "In too many cases," the committee concluded, "the state doesn't know what happened." Of the 40,000 mental patients estimated to live in New Jersey, perhaps 5,000 received some kind of state-financed outpatient treatment, and 7,000 were cared for in state-licensed boarding homes, but the whereabouts of the rest were a subject of some mystery. Many of the old resort hotels that were failing to attract customers have been converted into unlicensed and unsupervised boarding homes for the elderly, the physically handicapped, and the mentally impaired. One boarding home owner told the committee that whenever he had a vacancy, he simply called the state hospital and had a new patient sent over.

In their eagerness to reduce mental health costs, legislators heard only half the reformer's cry, "Shut down the large ineffective state hospitals and replace them with small active treatment community programs." Legislators reduced the hospitals without creating community facilities and programs for the discharged patients. The success of state mental health programs was measured in the ability to discharge patients and reduce the resident hospital population. From the standpoint of communities ill-prepared to receive the tens of thousands of former state hospital patients suddenly in their midst, de-institutionalization became known as dumping.

Of the 83,000 adult patients released by psychiatric hospitals in New York State between 1974 and 79, nearly half gravitated to New York City. Officials of the New York City Department of Mental Health estimate that 20,000 chronically mentally ill people are concentrated in the city's single occupancy hotels, while 4,000 more live in proprietary boarding homes, and the number living on the streets is unknown.

The Borough of Queens was hardest hit by the program to empty out the state hospitals. Queens Borough President Donald R. Manes declared, "The snake pits are being transferred from the institutions to the neighborhoods." De-institutionalization created a schism between city and state mental health systems. Robert Reich, Director of Psychiatry for New York City's Department of Social Services in 1974 called state policy "immoral and inhumane" and demanded a moratorium on administrative discharges from mental hospitals to communities "that cannot provide an appropriate and safe place ... to live." Dr. Reich added that "Freedom to be sick, helpless, and isolated is not freedom." The City of Long Beach, Long Island, sued three State agencies in 1974 for placing more than 700 discharged mental patients in its midst without providing proper care or supervision. The suit maintained that the state "failed to safeguard the health and safety of these persons and thus failed to protect the City and its residents from the influx of former patients." In reply, Harold Wolfe, Associate Commissioner of the State Department of Mental Hygiene, described his Department's dilemma, "We are accused of dumping patients in neighborhoods. And we are accused of imprisoning patients in violation of their civil rights." A 1981 report by the Community Services Society of New York City stated that the problem of the homeless on city streets has reached such "extraordinary proportions" that emergency housing must be established immediately. The Society estimates that there are more than 36,000 homeless people in New York City with an estimated 3200 beds in public shelters. Following an audit of the New York State de-institutionalization program, the City Comptroller concluded, "The only beneficiary of the State's effort to send mental patients back to their local communities has been the (State) treasury."

Some 15,000 mental patients from Illinois mental hospitals congregated in an area called "Uptown" in Chicago. San Jose, CA., inherited more than 2,000 discharged patients when nearby Agnews' State Hospital closed half of its wards. Local entre-

preneurs purchased several abandoned fraternity and sorority houses adjacent to San Jose State College to create a psychiatric enclave known locally as "Little Agnews." Half the patrons in the men's shelter on the Bowery in Manhattan, intended originally for homeless alcoholics and derelicts, are former mental patients. In cities across the nation, neighborhood residents are protesting the location of halfway houses and board-and-care homes in their midst. In 1975 the Alabama Supreme Court affirmed a lower court injunction against the operation of halfway houses in residential areas. The high court said that it was not holding such facilities to be "nuisances per se" but that they may become nuisances by virtue of their location in a residential area. In Sacramento, CA., local residents accused the State Department of Health of attempting to turn their neighborhood into "mental health row."

An unknown number of former patients have become street people sleeping in doorways, under bridges, in the sewer system, condemned buildings, garages, and flop houses. So many former patients congregated in and around the Library of Congress that the Psychiatric Institute of Washington was asked to initiate an unprecedented 19-week course for library personnel entitled, "Successfully Dealing with Disruptive and Disturbed Patrons." The Director of the Psychiatric Institute's Crisis Intervention Center described the Library of Congress as "like the day room of a state mental hospital." Familiar characters among the patrons have been given names by library staffers based on peculiarities of behavior. The roster of characters includes the "Bag Lady" whose body odor is sufficient to clear out an entire reading room, "Robin Hood" a tall man wearing a quiver of arrows on his shoulder who sits in front of the microfilm screen everyday reading the Los Angeles Times, "the Button Lady" who dresses like a Nun and accuses everyone in sight of being an FBI agent, a naked man caught doing his laundry in the first floor men's room, another man who wears styrofoam cups over his ears to block out radio signals from China, and "Mr. Gloves" who has a nasty habit of cursing and jostling with library staff members if they try to quiet him. Some former mental patients have been recruited into the ranks of migrant farm workers. Testifying before a presidential commission on farm workers, Richard D. Morrison charged that some of the statistical successes of de-institutionalization are "Truly dismal failures, since many of the still-disoriented, confused and troubled former patients drop from sight of after-care programs to be shanghaied into the migrant labor force by ruthless farm labor contractors, there to lead lives characterized by brutality and misery and early death."

The courts have established the civil rights of the mentally ill street people. It is not sufficient for people to be overtly psychotic to deprive them of their liberty. Nor can they be forcibly given medication even if this can be shown to benefit them. The psychotic street people are left to wander until they break the law or can be proven to be a danger to others. Danger to self is barely accepted in some courts and in others provides justification only for brief periods of confinement. Ask the nearby policeman what can be done about the disheveled young man in the tattered coat shouting warnings about the end of the earth to passers-by and cursing imaginary plotters, and the policeman will probably shake his head and declare that nothing can be done until the young man breaks the law. Inquire about the old woman living under the railroad bridge in 20° weather, and carrying all her possessions in a shopping bag, and the policeman will again shake his head and tell you about First Amendment rights.

The move to de-institutionalize treatment of the mentally ill had two major outcomes. The first was to allow the mentally ill to remain in society. For this policy to succeed required an increase of tolerance among the public toward deviant behavior. It also required facilities, programs, and shelter for the former patients. In those urban areas where former mental patients have congregated, there are frequent newspaper reports of their accosting people on the sidewalk, urinating in public, exposing themselves, etc. Generally these are not serious

incidents but minor annoyances, of less concern to the local residents than rampant crime, but symptomatic of the role of the State in creating problems for local communities without providing solutions. State government has given up responsibility over the former residents of mental hospitals, local government has not the resources to assume this responsibility, and the federal government has not been willing to take over what could become a hugely expensive program. Most board-and-care facilities and halfway houses have been located in marginal urban areas, subjecting the mentally ill to the high crime and low resource and opportunity costs of these areas. Few are located in the suburbs or middle-class city neighborhoods.

By refining the distinction between being a danger to others and being a mere nuisance, the courts largely remove the power of psychiatry to institutionalize people who violate social norms. The courts have in effect told the public that it must tolerate mere nuisances. Providing resources or refuges for them has not been considered by the courts to be a priority issue.

PART II: IN PRISONS AND JAILS

Darline June Cromer was convicted in 1981 by an Oakland, CA., jury for the murder of a five-year-old black child and sentenced to life imprisonment without possibility of parole. Upon hearing the sentence, Cromer's Mother had to be physically removed from the courtroom after shouting, "She is insane, she is insane." Cromer had a history of mental problems going back at least a decade. A jailer testified that Mrs. Cromer had told her, "It is the duty of every white woman to kill at least one black child." On other occasions, Cromer had expressed the view that blacks and orientals were placed on earth like chickens and cows to be eaten. Defense psychiatrists testified that she was insane when she strangled the boy. Nonetheless, the jury rejected the insanity-defense and convicted her of first degree murder.

Richard Chase had been dubbed "The Vampire Killer" because of his tendency to drink the blood of his victims in what the local Sheriff described as "The most grotesque crimes I've ever seen." Chase had been in and out of mental hospitals for years prior to his conviction, and had just been released from a one-year conservatorship following his last admission. After his arrest, Chase admitted to killing six people and drinking the blood of two of them. He had been hospitalized in 1976 for blood poisoning after an attempt to inject himself with rabbit blood. He began staying in bed for 24 hours a day after that, and dialed doctors picked at random from a telephone book to complain that his stomach was growing backwards and that he had heart problems (tests showed that he did not) and later ran away from home because, he explained, people were taking his tee-shirts from his suitcase and putting them on dead bodies and he accused his mother of poisoning him and sending him telepathic messages. During the trial, he raved incoherently and hallucinated as the witnesses presented evidence. Despite his obvious mental disturbance before and during the trial, Chase was convicted of first degree murder and sent to prison where he was ostracized by other inmates for his odd behavior.

In 1973 Hubert Mullin shot and stabbed 10 persons to death in a crime spree in Santa Cruz, CA., for which he was convicted of first degree murder. After the verdict was in, the jury foreman declared, "Only an individual with a mental discrepancy could have committed these crimes." Five times prior to his arrest, Mullin had been in and out of mental hospitals and the jurors believed that a sixth commitment would only result in another early release.

Such cases, in which obviously psychotic individuals are convicted of major crimes, reflect not only a disenchantment of juries with psychiatric testimony and the criteria for establishing mental illness, but also a rejection of the centuries-old distinction between the insane and the criminal defendant. The usual criticisms of psychiatry, that its diagnoses are vague and unreliable, its treatment methods quixotic and ineffective,

its predictions of recurrence of future violence unreliable, seem less important to jurors in the final analysis, than the inability of psychiatry to keep disturbed and dangerous people off the streets. These doubts have rendered psychiatric testimony largely irrelevant in cases where dangerousness is an issue. When an insanity plea is offered by the defense, the key questions for the jury are no longer concerned with the presence or absence of mental disturbance but whether the person should be kept off the streets; and, if so who is best able to accomplish this. In the cases cited earlier, the jurors lost confidence in the mental health system to serve a containment role. Faced with the choice between an uncertain commital in a mental hospital and a lengthy period of incarceration in prison, the juries opted for the latter alternative.

In 1980 the Indiana Legislature passed a law giving judges sole discretion over whether to release individuals ruled mentally ill. It also allows jurors the option of finding a defendant "guilty but mentally ill" in which imprisonment follows treatment in a mental hospital for the duration of the sentence. This law resulted from decisions such as that involving Leonard Smith who was accused of killing California Angels outfielder Lyman Bostock, and found innocent by reason of insanity by the jury and committed to a mental hospital. Seven months later, a circuit judge ordered Smith released when psychiatrists testified that Smith was not mentally ill. According to Indiana law, the judge did not have the option of keeping him in a mental hospital if the staff did not consider him mentally ill. In Philadelphia, Penn., Winifred Ransom had been committed to a mental hospital after killing a pregnant woman and cutting out her baby. Seventeen months later the judge who made the original commitment received a letter from hospital psychiatrists recommending that Ransom be released. They stated that Ms. Ransom "Remains schizophrenic, but no longer requires inpatient treatment." The judge protested, "If you discharge her, she is your responsibility not mine. I really cannot understand how you can recommend discharging the client to go out into the community and resume a normal life." In twin verdicts that the judge was moved to describe as "contradictory," a jury found Harold Thomas Francis, who had a 15-year history of being in and out of mental hospitals, innocent by reason of insanity in the murder-robbery of a fellow patient but then turned around and convicted him as an accessory after the fact. The jury explained that they believed that the defendant was insane during the murder but knew what he was doing when he tried to escape. In the opinion of outside observers, the coupling of the two verdicts was the jury's attempt to confirm the defendant's obvious mental illness which was a matter of record, and also to convict him of something so that he would not walk free as soon as his mental condition stabilized.

Until the 1960's, a jury could choose between two methods of incapacitation for a mentally ill defendant in a criminal case. The individual could either be convicted of a crime and sent to prison or be judged mentally ill and confined in a mental hospital. Either way there was great likelihood that the person would be off the streets for a long time. In capital cases particularly, admission to a state hospital for the criminally insane would likely result in a longer period of confinement than would a fixed term in prison. This system was open to criticism from civil libertarians on the grounds that a patient's stay in mental hospital was open-ended and the criteria for commitment and discharge were vague and capricious. It was relatively easy to commit people to a state institution and once committed, it was hard for them to gain release. Institutional psychiatry was left alone by the courts who declined to review the adequacy of care or treatment. Some defendants judged to be mentally ill spent more time in a mental hospital than they would have spent if they had been convicted of crimes. Some people judged unable to plead never received a trial and so spent years in a hospital without guilt or innocence ever being resolved. Conditions within the institutions *were* often deplorable. All this changed in the 1960's with a series

of landmark court decisions establishing a patient's right to treatment in humane surroundings and broadening the civil rights of committed patients. Paralleling the court decisions were legislative statutes setting narrow criteria for involuntary hospitalization. These have been genuine victories for civil libertarians, but they have not been won without cost. Treatment in a mental hospital today is far more expensive than it used to be. Many state hospitals calculate their per-patient cost to be anywhere from $15,000 to $40,000 per year and now have a waiting list for admissions, something that was inconceivable in the bad old days of easy committal and difficult discharge. As a result, the courts are increasing their use of judicial orders to require state hospitals to accept patients. Currently 40 percent of California's hospitalized mentally ill are there on some kind of judicial order. The scenario goes something like this. If a psychotic man is disturbing the peace and resists arrest, the police no longer try to get him hospitalized directly. Instead they charge him with a crime, and then find him unable to stand trial. At that point the court orders him to be sent to a mental hospital for examination and treatment. This subterfuge compels the mental hospitals to accept patients whom they might not otherwise admit.

Another result of court decision expanding the rights of the mentally ill has been what Psychiatrist John Talbott describes as transinstitutionalism. Jurisdiction over the mentally ill is being transferred from the mental hospital system to the prison system, where it had resided over a century ago before the intervention of Dorothea Dix and other humanitarians. Jails and prisons across the nation are housing people who used to be sent to mental hospitals. From the standpoint of civil libertarians, two benefits of this arrangement are that the mentally ill prisoners are now told the nature of the offenses for which they were convicted and how long they must serve. These two pieces of information, assuming the inmate can comprehend them, were not available to patients of several decades ago who neither knew the offenses for which they were charged nor how long they would be incarcerated. The gains in information and personal control must be balanced against the exposure of seriously disturbed individuals to the tense and dangerous environment of the prison and the effects of the mentally ill on other inmates, staff, and the institution. In 1975 the influx of the mentally ill into the state prisons with the closing of California's mental hospitals prompted then-director of the State Department of Corrections to declare, "I would welcome lawsuits to remove these inmates from the prisons and transfer them to other state facilities." The situation has worsened since then. Lt. James Burlson of the Santa Clara County (CA) Sheriff's Department, declared, "Our jail population has at least tripled with the people who require hospitalization or antipsychotic medication. We pick them up for loitering and mischievous conduct."

According to Suzanne Tavano, Director of Psychiatric Services for the San Francisco Jail, the number of mentally ill prisoners in the jail accused of serious crimes has grown 70 percent in the last year with about one in every 12 prisoners classified as mentally ill. Because of this crowding, it is no longer possible for the jail to segregate its mentally ill in isolated wings. Now they are placed on the mainline where their behavior keeps the entire jail in an uproar. Sometimes the prisoners are kept naked, jail officials explain, so that they cannot hang themselves or harm others with their clothing (sic). They are also not given medication because it is illegal for jail authorities to give drugs to prisoners without consent.

Patrick J. Murphy, Chief of Operations for the New York City Police Department, estimated that his unit handled 21,000 of "emotionally disturbed persons" in 1980. To meet the problem, the Department has obtained nets and fire extinguishers to subdue the seriously deranged. Across the nation, jurisdiction over the seriously mentally ill is being transferred from the mental health system to the police and the prison system.

The cases of the mentally disturbed individuals charged with capital crimes cited at the beginning of this article represent only the tip of the iceberg. These are unusual

examples because most mentally ill are not likely to attempt to assassinate a public figure or hijack *an* airplane. The notoriety attending such cases makes it easier to understand what is happening than in the more common situation of mentally ill street people being picked up and sent to jail for loitering, mischievous conduct, or disturbing the peace. The effects of the mentally ill on the other jail inmates must also be considered.

Overcrowding has made double-celling a routine practice. Some cells are very small indeed. One of us testified as an expert witness in a lawsuit protesting crowding at the King County Jail in Seattle, Washington, where four men are confined in cells 8' x 7'. At Deuel Vocational Institute in Tracy, CA., the scene *of* continuing inmate violence, double-celling is increasing in cells whose floor space measures 6' x 9'. Imagine the effects upon even a psychologically robust person of sharing such a small space with a mentally disturbed individual. Centuries ago, to be confined with a madman was a recognized torture. The presence of a psychotic inmate can be destructive to an entire tier. There was no great outpouring of surprise or dismay among inmates or the general public when Richard Chase, the psychotic "Vampire Killer" mentioned at the outset of this article, committed suicide in his cell on San Quentin's Death Row. With such conditions, the mentally ill and the well inmate are both receiving gratuitous punishment.

We do not believe that anyone can seriously maintain that prison is a suitable environment for the mentally disturbed. The criticisms voiced by patients' rights groups and the antipsychiatry movement regarding the vagueness of psychiatric diagnosis and the ineffectiveness of treatment will come back to haunt those who might try to improve the lot of the mentally ill prisoner. If mental illness is a myth and treatments ineffective, then it makes no sense for the courts to mandate mental health programs or personnel within penal institutions.

PART III: EPILOGUE

The movement toward deinstitutionalization had several unintended consequences that are not in the interests of former mental hospital patients or of society. The first is the widespread disenchantment among the public with the ability of institutional psychiatry to keep disturbed and dangerous individuals off the streets. If one believes that psychiatry should not have the power to hold people involuntarily, this situation is both appropriate and desirable. However, it is disingenuous for psychiatry to relinquish control over mentally ill offenders without consideration of what will happen to them. Incapacitation of the mentally ill offender has been transferred to penal institutions where conditions of care, confinement and treatment are far worse than they had been in mental hospitals. The second unintended outcome of deinstitutionalization has been the aggregation of the mentally ill in marginal urban enclaves without any care or treatment being provided for them. Society must eventually decide whether the neglect of the mentally ill street people and their diversion to prisons and jails represent advances in humanitarianism or a return to a prior barbarism.

Although these outcomes were unplanned by the advocates of de-institutionalization, they were not unpredicted. There were warning voices sounded throughout the campaign to empty out the mental institutions that nothing was being provided on the outside for the former occupants. These critics were dismissed as Neanderthals, primitives, and reactionaries, impeding the triumph of the new social psychiatry. "Community treatment" became a catch phrase, without serious consideration of the nature of community or the availability of treatment. The "community" to which a former hospital patient gravitated was typically **not** the community from which the patient had been admitted, and the other residents were not caring friends and family grateful to have their long-lost neighbor back in their midst. Those districts in which the former

patients live mostly marginal existences do not qualify as communities, at least as far as the mentally ill are concerned, and the facilities available are woefully inadequate for their social, medical, and even survival needs.

Court decisions and legislative acts expanding the rights of state hospital patients will be not only meaningless but actively harmful if the net result is a massive transfer of people from the status of mental patients to that of criminals. An inevitable result of the erosion of the distinction between the criminal and the insane defendant will be a line of disturbed and hallucinated individuals in front of the electric chair and the gallows. Those who oppose capital punishment will find this as revolting as our forebears did 500 years ago. Those who believe in capital punishment, should be opposed to this perversion of a measure which can only lead to public revulsion.

While psychiatry's posture has not been especially edifying, lawyers appear to have acted even worse. Under the guise of protecting patients' liberties, they are subjecting them to imprisonment whose destructive effects on the human psyche have been well-documented for over two centuries. Added to this, the mentally ill on the streets are not producing greater tolerance for deviant behavior, but encourage clandestine reprisals and persecution. Attention must be given to those people formerly directed to psychiatric facilities who are now either turned away or trans-institutionalized. The mentally ill sleeping in doorways, panhandling and living in the sewers are mostly withdrawn, sad, and occasionally angry people. It does not take much psychological sophistication to see how such an individual could commit an outrageous crime in order to attract attention. Fred Saloman, aged 24, was killed by a SWAT team sharpshooter, after he had raped and stabbed a woman, wounded one of four hostages, and tried to hijack a Continental Airlines 727 jet. Saloman had twice sought treatment in a mental hospital, but was not held beyond the initial 72-hour observation period. Hostages quoted Saloman as telling them, "They told me to go get a gun and kill somebody and then maybe they would commit me to a mental hospital."

All the reports indicate that the mentally ill are not adequately housed or cared for in penal institutions, and that they are worse off in prisons and jails than they had been in mental institutions. Their presence is also extremely disruptive for other inmates and on institutional routine. Besides the sheer time and effort involved in dealing with them, prison staff do not know how to handle the psychotic who is shunned, ostracized, exploited and occasionally brutalized by other inmates.

Although continued vigilance is needed to safeguard the rights of those in mental institutions, an impressive list of safeguards has been erected by courts and legislators. As a priority issue, we feel that psychiatric reformers should direct their attention to the plight of the impaired street people and the mentally disturbed in jail. The long-term outlook for schizophrenia was unchanged by the tranquilizers. What they accomplished was not to increase recovery but to change the degree of impairment. Consequently there are more impaired people who need asylum. This could be in city shelters with adequate amenities, food, and recreational opportunities or in farm houses. Added to this are acutely disturbed people who cannot get into hospitals and do some frenzied act to obtain what the law wishes to protect them from. We strongly believe that trans-institutionalization from mental hospitals to prisons is not an adequate solution for the mentally disturbed. The correctional system has a lackluster record in handling convicted felons and neither the inclination nor the ability to handle the mentally disturbed. On the surface this resembles a return to the bad old days before the mass emptying out of the psychiatric wards. However, significant changes have occurred since that time. Procedural safeguards regarding admission and treatment policies are now firmly entrenched. Locked psychiatric wards are now subject to minimum standards. There are periodic inspections by outside agencies such as the Joint Commission for the Accreditation of Hospitals. The rights of

patients to due process and treatment in humane surroundings have been affirmed by court decisions. With these safeguards in place, we believe that locked psychiatric facilities continue to play an essential role for mentally disturbed who cannot be housed in less secure facilities. Existing reimbursement and cost-sharing plans involving federal, state, county and local government need to be examined and overhauled to match appropriateness of treatment. The present system produces massive paperwork and the inappropriate assignment of individuals to facilities for bureaucratic convenience to obtain maximum third-party reinbursement. The nomenclature of mental health facilities needs to be revised to more adequately reflect the goals and functions of each type of facility.

At some point the plight of the mentally ill street people and those in jail will take on the proportions of a national scandal. We should surely try to do as well by those described by the Earl of Shaftesbury as "the most helpless if not the most afflicted of the human race," as did reformers a century ago.