California mental

From the snakepit

California began emptying its mental hospitals nearly 30 years ago, when community-based care was touted as the more humane alternative. As thousands of homeless mentally ill wander city streets, or end up in jail or prison, policy-makers wonder: Where is this 'community care', and isn't there a better way?

By Sigrid Bathen

health care: to the street?

We got into much of the current mess by acting on the best intentions without forseeing the worst of unintended effect.
— Joseph A. Califano, former secretary, U.S. Department of Health, Education and Welfare, Carter administration

How could we have been so blind?
— Dr. Jerome Lackner, former director, California Department of Health, Jerry Brown administration

The acute psychiatric unit of the Sacramento County Jail is located on the second floor of the towering, state-of-the-art new jail in downtown Sacramento, where some 2,000 inmates are housed. On this late summer morning, there are 11 prisoners in individual cells on the psych unit, including one severely disturbed woman who keeps trying to stuff food, or whatever else she can get her hands on, into an open incision in her chest. Every inmate in this jail-within-a-jail is severely disturbed — dumped into an already overburdened criminal justice system ill-equipped to handle them.

Nowhere are the failures of California's mental health system more glaringly apparent than in its jails and prisons. In an odd quirk of governmental happenstance, law enforcement authorities have

been thrust into a highly unusual role as perhaps the most compelling advocates for improved community treatment for the troubled and sometimes dangerous people who are an increasingly difficult presence on the streets of California cities, in large measure as a result of the "deinstitutionalization" of state hospitals over the past three decades.

"We don't have a mental health system," says Assemblyman Don Perata (D-Alameda), a former Alameda County supervisor whose sister is a diagnosed schizophrenic. "Our homeless problem is really a mental health problem. Patrol officers serve as shepherds between the point where they pick up a homeless mentally ill person and the time they deposit him or her in the psych ward. That's what passes as a mental health system in California."

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California Mental Health Department Director Dr. Stephen Mayberg takes a somewhat less jaundiced, but still critical, view: "Deinstitutionalization was sort of the beginning of the difficult times. The state hospitals went from 35,000 to 5,000, and the community was expected to deal with it without the expertise or the resources. It was a recipe for problems, and we've spent a long time trying to dig ourselves out of that hole."

Legislative solutions have focused in recent years on reorganizing the maze of county, state and federal programs which govern or finance mental health — and on easing patient access to new "wonder drugs" to treat serious mental illness, as well as force the burgeoning managed care industry to pay for mental health treatment as it does for so-called "physical" ailments. Increasingly, research shows a clear biological basis for mental illness, but the HMOs have aggressively resisted expanding mental health coverage, if they provide it at all. "We have to approach [mental health treatment] in a lot of ways," says Assemblywoman Helen Thomson (D-Davis), a former psychiatric nurse. "One way is to get insurers to cover [mental illness] so patients aren't bankrupted, so there is early diagnosis and treatment. There is a much better outcome, and ultimately it's cost-effective." Thomson-Perata legislation to require HMO coverage for severe mental illness faced a threatened veto by Governor Pete Wilson, but a bipartisan measure to greatly expand Medi-Cal prescription coverage for mental illness was included in the state budget.

As state policy-makers wrestle with what are admittedly piecemeal solutions to an increasingly intractable problem, the front-line soldiers in the mental health wars are very often cops, at enormous cost to the state. A recent study by the Pacific Research Institute placed the annual cost of the mentally ill to the California criminal justice system at between $1.2 billion and $1.8 billion. Sacramento County Sheriff Glen Craig says he runs the "second-largest mental health facility in the county" — the first being the county mental health treatment center where the indigent mentally ill are taken, often by police officers. Law enforcement authorities in Los Angeles County say flatly that they run *the* largest mental health facility in the county — the Los Angeles County Jail. The U.S. Department of Justice recently ordered the county to improve its treatment for mentally ill jail inmates or risk a federal lawsuit.

"The actions of two governors — [Ronald] Reagan and [Jerry] Brown — dropped a major problem on the streets of California," says former San Jose Police Chief Joseph McNamara, a noted criminologist and author of several books on crime who is now a fellow at Stanford University's Hoover Institution. "While many of these people have accumulated long arrest records, most are more disturbed than dangerous."

Dr. Jerome Lackner, who as state health director under Governor Jerry Brown initiated an intensive investigation of patient neglect and mistreatment in the state hospitals in the 1970s, says the community care touted by deinstitutionalization advocates, like himself, never really existed. "What little there was of a community mental health system when we let everyone out has progressively diminished," says Lackner, who now specializes in alcoholism and drug abuse treatment and treats many patients who also are mentally ill. "In the last three or four years, the dimunition has been absolutely wrenching: closed clinics, closed services, laid-off caregivers. There was an inadequate system to begin with, and it's become more inadequate. ...The only long-term treatment for the mentally ill is when they finally break a law and do something really terrible."

Dr. E. Fuller Torey, a psychiatrist at the National Institute of Mental Health and author of 12 books on mental illness — including the recently published "Out of the Shadows: Confronting America's Mental Illness Crisis" — cites a 1975 California study that found nearly 7 percent of the state's jail and prison population was mentally ill. Today, some estimates go as high as one-third. "Jails and prisons have increasingly become surrogate mental hospitals for many people with severe mental illness," says Torrey.

One California prison psychiatrist summarized the mental health crisis in prisons when he told Torrey: "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."

As an example of the impact on local facilities, Torrey cites a 1973 study in Santa Clara County indicating that the jail population rose 300 percent in the four years after the closing of Agnews State Hospital. A 1975 study of five California jails by Arthur Bolton & Associates concluded that the number of severely mentally ill prisoners had grown 300 percent in the preceding decade. California was one of the most aggressive states in pursuing deinstitutionalization after passage of the landmark Lanterman-Petris-Short Act in 1969, and the statistics clearly show that many of the mentally ill ordered released from state hospitals to "the least restrictive alternative" were instead landing in the most restrictive — jails and prisons. Most are charged with misdemeanors like trespassing or petty theft, and Torrey says a "surprising" number are "mercy bookings" by police, particularly for homeless women often victimized by sexual predators. "At least you know they'll be safe and fed," one Los Angeles police captain told Torrey. Others, described by Torrey as

"walking time bombs," commit serious, violent crimes.

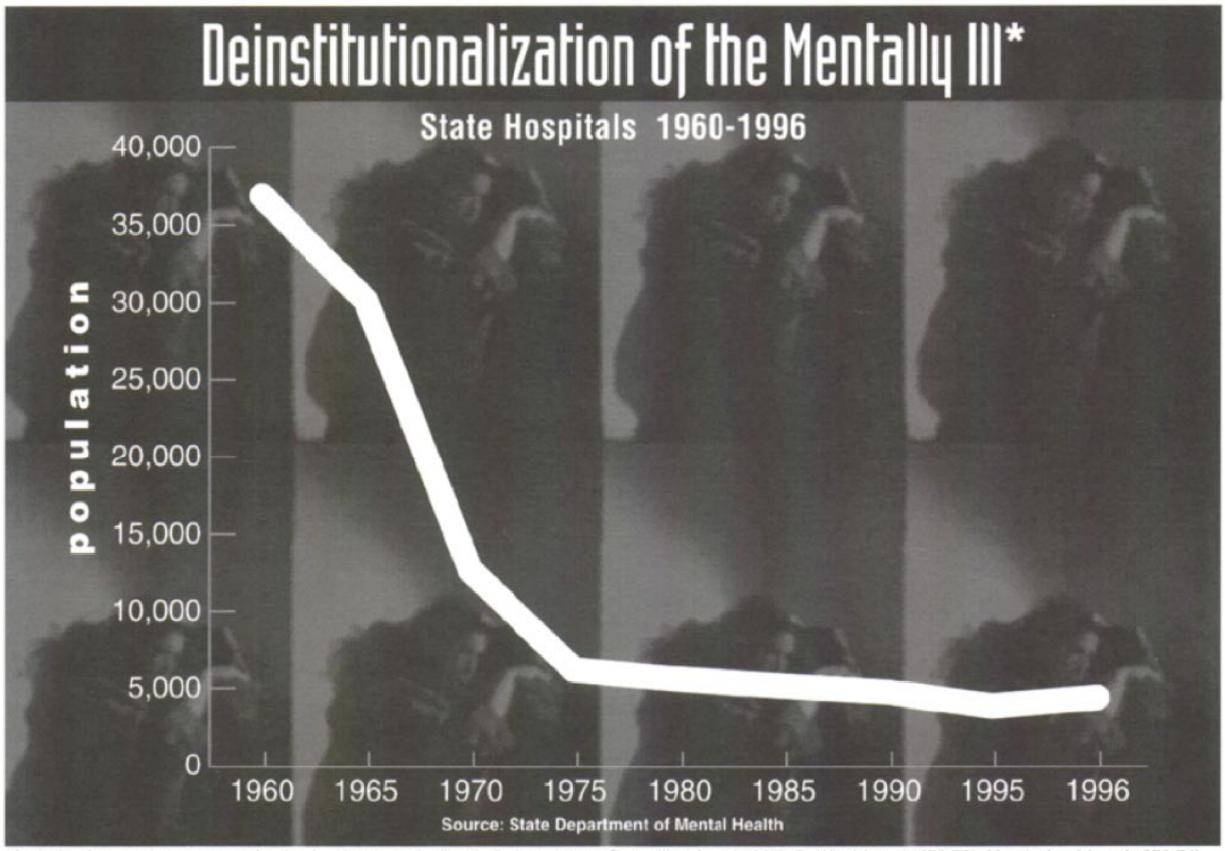
Judy Johnson remembers one of those. A registered nurse who runs the psychiatric unit in the Sacramento jail under contract with the University of California-Davis School of Medicine, she has worked for nine years in the jail, the last four as program director. Several years ago, an inmate charged with a particularly brutal attempted murder was sent to the acute unit. A man in his early 20s, he had been in and out of jail and mental hospitals for most of his life, including a three-year stay in Napa State Hospital as a teenager. He had recently been released from one of many prison and jail terms when he tried to kill a woman — in broad daylight on the streets of Sacramento — and stole her car. The woman was seriously injured, but survived.

"He was well-known to us," says Johnson. "When he was here he was very difficult to deal with in a jail setting. He was a diagnosed chronic paranoid schizophrenic with bipolar disorder [manic-depression]. He would get a couple years in prison, get 'good time,' be released. He would get medication in prison, but when he was not on his meds he was very difficult to handle. He was self-destructive, would scratch himself, cut on himself, make weapons, threaten staff, bang his head, beat on the window, fight officers. He said he heard voices and became quite paranoid." After 87 days in jail custody — 68 on the acute psych ward — he was recently sentenced to 31 years in Atascadero State Hospital.

"He was the scariest guy I've ever seen," says Johnson, who has seen her share. "We've got one right now who's the same, although he is also sexually dangerous. He sodomized someone with a baseball bat after knocking him out." The long history of the young schizophrenic fills five fat, dog-eared volumes.

On this Monday morning in the middle of August 1997 in the Sacramento jail psych unit, visitors are not told who has done what to whom, or the identities of inmates. One man, brought in violent and delusional, required seven Sacramento police officers to restrain him. He is in one of two "safety cells," submarine-like padded rooms with only a drain in the floor, visible to officers on a video monitor. The individual cells — double-celling is impossible here — have only a narrow steel bed with a plastic-covered mattress, a steel sink and toilet. One man looks like he's talking on the phone, but of course there are no phones. In one cell, there is a man in a "blue suit" — a blanket-like quilted garment, rather than the standard-issue orange jumpsuit, designed for the suicidal because it cannot be torn.

An officer in the black uniform of Sacramento sheriff's deputies stands by an open cell door, talking with an inmate who has become more "manageable." This is entirely voluntary duty, and it takes a special breed of cop to handle this place — one with an endless reserve of patience, some tolerance for the frequently bizarre behavior of the inmates, as well as the ability to handle them humanely when they become violent. The civilian UCD medical personnel, including doctors, nurses, social workers and clerks, are not permitted to be with an inmate unless an officer is present, and sometimes the officers have to perform "cell extractions" to get an inmate out of his cell for the required legal hearings



* Includes Agnews (now a center for the developmentally disabled), Atascadero, Camarillo (closed 1997), DeWitt (closed 1972-73), Mendocino (closed 1973-74), Metropolitan, Modesto (closed 1970-71), Napa, Patton, Stockton (closed 1996). Does not include developmentally disabled (mentally retarded) residents in these and other state hospitals, whose numbers have experienced a similiar decline.

Dr. Jerome Lackner

on forced medication, or to take him to court, or to release him. Jail staff attempt to ensure some follow-up treatment, but know their efforts are often futile. "It is more likely that they will not get follow-up than that they will," says Craig. Officers and UCD medical staff have little time for the psychiatric therapy these inmates desperately need. Many inmates soon return, some again and again.

In a curious melding of correctional and medical terminology, some 130 to 150 inmates also are treated on an "outpatient" basis, which means they are in the general population of the jail but have been identified as mentally disturbed and receiving medication. Some are housed together in a "pod" within the jail, others throughout the jail. The waiting list for treatment is long — 92 waiting for appointments on this day, 20 of those identified as "priority."

"We are just swamped," says Johnson. "We have waiting lists within waiting lists and obviously cannot meet the needs of the population." A random sampling of all jail bookings in April 1995 by Dr. Daniel Edwards, a UCD clinical psychologist who is associate clinical director for jail psychiatric services, revealed that 19 percent of the inmates booked that month had previous contact with the county mental health system. That number did not include those who may have received treatment outside the county. "We believe the actual figure is much higher," says Johnson.

Across town at the county mental health treatment center, where mentally disturbed people are brought by police, caregivers or sometimes come in on their own, patients walk around more freely, although the facility itself is secure and locked. The difference between this group and those in jail is not always clear, except that they haven't been charged with crimes. Center Director Kathleen Henry and Sacramento County Mental Health Director Tom Sullivan, both licensed clinical social workers with long experience, say staff assaults are common. One memorable female patient left 14 staff members needing medical attention for bites, scratches and bruises.

People will stay anywhere from 23 hours to days or even months. The involuntary 72-hour holds under Section 5150 of the state Welfare and Institutions Code are common, as well as 14-day and 30-day holds, for which hearings must be held before an administrative law judge. The average stay is about a week. In one unusual case, a mentally ill AIDS patient died in the facility after 18 months; there was nowhere else for him to go. Some 700 people are seen every month at the center, which has a capacity of about 80, although less than one-third are admitted as inpatients. Many patients are repeat visitors, although outpatient community followup is somewhat more successful than with jail inmates; while clearly unable to keep pace with demand, counties operate a variety of community services for outpatient treatment.

On this pleasant, sunny day in mid-August, patients are milling about, some staring vacantly in day rooms, some asleep in their rooms, others outside in the enclosed courtyard. One is feeding a rabbit in a cage. A 15-year-old boy brought in after an overdose of pills — he had just been released from a mental facility when he took the pills — is in a separate room. He tells staff he will do it again until he is removed from his home. Children are generally not kept more than 23 hours in the center, instead going to group homes or other facilities. Mental health treatment for kids is an escalating problem in California, and facilities to treat them are woefully inadequate. "With the increase in child abuse," says Sullivan, "it's only going to get worse."

At one point, a wild-eyed woman approaches visitors, speaking incoherently. She says she has a husband and five children, but their whereabouts are unclear. She had been found by police, screaming and partially clothed, on a downtown street, apparently on drugs, but she refused a toxicology screening. Although a clinical diagnosis is difficult at this early juncture, she is believed to be suffering from paranoid schizophrenia. She was released after two weeks to a relative in another state.

As the state hospitals have emptied, community care has devolved to the increasingly financially strapped counties, where for many years mental health funding has been on a fiscal roller coaster, subject to the vagaries of the state budget. In 1991, "realignment" legislation created a more stable funding source by earmarking a certain percentage of the sales tax and the vehicle license fees for mental health funding. But that was in the middle of the recession, so the funding was hardly rich. The California Psychiatric Association estimates that one-fourth of Americans suffer from some type of brain disorder, 2.8 percent of them severe. Yet California currently ranks 48th among the 50 states in per-capita expenditures for mental health.

"Through the '80s, there was growth in [community] programs," says Mayberg, a clinical psychologist and former Yolo County mental health director. "The economy was good, and people were willing to put some money into mental health. When the economy turned bad, it was the largest [non-mandated] program, and it was the easiest to cut. The mental health community was fractious, competing, arguing — sort of like starving people at a handout, fighting over scraps. There was no coherence in mental health planning, and nobody was looking at whether we could turn the scraps into a meal."

In late August 1997, state hospitals for the mentally ill housed 4,386 people, — down from more than 36,000 in 1961 — and most of those are criminal or civil commitments.

In addition, there are approximately 4,000 developmentally disabled in state hospitals, now called "developmental centers," down from a high of about 35,000. Tracking the number of mentally ill in community programs is more difficult. "Clearly, we need to build more capacity at the community level," he says. "The new research seems to indicate that, for those with the most serious impairment, the broader array of interventions we can offer, the better they get — better housing, more jobs and job training, more support groups, more socialization. When you get a job, you *have* to get up and take your medication, take care of your hygiene."

Steve Thompson, the California Medical Association's principal lobbyist and a former top legislative staffer who helped write the Lanterman-Petris-Short Act in the late 1960s, cautions against a return to state hospitals as a solution to the current mental health crisis in California. "We tend to see the warts and not the successes of deinstitutionalization," he says. "People see the walking wounded on the malls because they're visible, but they didn't see them in the state hospitals, as I did. There never were sufficient resources put out there [in the community]. Freedom carries pain, but that doesn't mean that those who can't function normally should be put out of sight, out of mind. That may be efficient, but it's not humane."

Dramatic strides in effective medications for serious mental illness have led to a spate of legislation around the country to ensure that people who need medication actually get it. "The last 10 years have brought about miraculous drugs," says Rusty Selix, executive director of the California Mental Health Association. "Ninety-five percent of what we've learned, we've learned in the last 10 years. The older drugs didn't always work, they weren't safe, and they were combined with a lot of inhumane treatment. A lot of people on the streets have had bad experiences in that system. Treatment didn't work, there were drugs with debilitating side effects. ...There is a whole generation of mentally ill who have experienced the horrors and are reluctant to trust."

The Legislature this year has taken several steps to address the problems. The state budget included a $19 million appropriation to enable Medi-Cal patients to obtain the new miracle drugs. If fully implemented, the action could negate the need for legislation proposed earlier this year to add the drugs to the list of those permitted under Medi-Cal. A key reform, already adopted in many other states, it could save the state as much as $1.25 billion in health care, social services and correctional costs associated with mental illness — if the drugs get to the patients and they take them as prescribed.

Another bill, AB 1100 by Thomson and Perata, is faring less well. It would require private health care insurers — HMOs — to provide treatment for severe mental illness in the same way they do for physical illness. Similar measures have been passed in other states, but Wilson has said he will veto any bill impacting HMOs until a state task force studying the controversial health care organizations completes its work in January. Perata believes future strategy should focus on convincing business leaders the idea is cost effective.

"Everybody has some experience with this," he said. "If it doesn't happen with this governor, it is within reach."