Mania and the Law in California: Understanding the Criminalization of the Mentally Ill

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In 1841, Dorothea Dix, a 39-year-old teacher and pioneer in the field of social work, volunteered to teach a Sunday school class in a jail outside of Boston. While at the jail, she was shocked to see large numbers of mentally ill prisoners held under inhumane conditions. She observed inmates who appeared to be mentally ill chained in cages, held in cells without heat, and saw them beaten with rods by their jailers. Ms. Dix, whose own father suffered from mental illness, was moved by compassion for their plight and began a crusade to create a system of care for mentally ill prisoners across the eastern United States. She successfully lobbied state legislatures, and 30 public psychiatric hospitals were created. In 1880, 40 years after she began her efforts, a census taken in U.S. jails found that only 0.7% of inmates suffered from mental illness (1).

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History seems to be repeating itself. There are again a substantial number of mentally ill individuals behind bars. In a review of the established literature, studies place the overall prevalence of mental illness in jails (where inmates are housed immediately after their arrest and while undergoing court proceedings) at 6%–15% and in prisons (where inmates serve long sentences) at 10%–15%, significantly greater than the community base rate of 2%–3% (2, 3). This may, however, be an underestimate due to strict diagnostic criteria used in these studies as well as a reliance on accurate self-report and full disclosure among those inmates sampled. A more recent study at Los Angeles County Jail indicated there may be a much higher prevalence of mental illness than previously demonstrated. When more sensitive screening criteria and interviews rather than self-report data were used, it was found that 28% of male and 31% of female arrestees had either a significant history of mental illness or were manifesting symptoms of mental illness at the time of arrest (unpublished 2001 data of M. Maloney).

Chronic, severe mental disorders appear to predominate among the incarcerated mentally ill. As reported by the Epidemiological Catchment Area Study (4), prevalence rates of schizophrenia and the major affective disorders are three to six times greater in the prison population than in the community at large. In particular relevance to this case, the rate of bipolar disorder is six times greater among prisoners than in the community.

The mentally ill began to appear in jails and prisons in increasing numbers in the early 1970s, shortly after the massive shutdown of state hospitals across the nation. The closure of state psychiatric hospitals began in the 1960s with the expectation that former patients would be cared for by the community mental health system; this expectation, however, was not realized, as indicated by a number of studies conducted in California. After the close of Agnews State Hospital in Santa Clara County in the early 1970s, the county jail mentally ill population increased 300% (5). A 1978 study in a California county showed that former hospital patients with no history of arrests when they entered the hospital were arrested roughly three times more often after discharge than the general county population (6).

A theory proposed by Penrose in 1939 (7) explained what occurred after the closure of state hospitals in the 1960s. Penrose theorized that a relatively stable number of persons are confined in institutions in any industrial society. In comparing the census in mental institutions and prisons in several European countries, he found an inverse relationship between prison and mental hospital populations. He proposed that the relationship between the two is dynamic: if the population in one is reduced, the other will increase to compensate. In 1955, there were 559,000 state hospital beds for a population of 164 million people, representing 339 beds for every 100,000 people. In 1994, there were 72,000 state hospital beds for a population of 250 million people, representing only 29 beds for every 100,000 people. This indicates that 92% of people who would have been living in state hospitals in 1955 are not living there today. Although the number of people in state hospitals has declined, the number of people in jails and prisons has risen significantly. Between 1980 and 1995, the total number of individuals incarcerated increased from 501,886 to 1,587,791, an increase of 216%. This increase is not sufficiently explained by a growing population: during the same time period, the population rose by only 16% (1). While tougher sentencing laws and the wide availability and use of illicit drugs have contributed to this dramatic rise in the incarceration rate, the criminalization of the mentally ill is likely an additional factor accounting for the tremendous increase in jail and prison populations (8).

We present a case of a patient in the manic phase of bipolar disorder and his treatment course across various settings: a local community mental health clinic, an aca-

demic hospital, and, eventually, a penal institution. This case provides a vivid illustration of some of the difficulties in treating manic patients and provides insight as to why some patients with chronic mania and other severe mental illnesses "fall through the cracks" of the community health system and end up in the criminal justice system. This case presentation highlights the risk factors that place them at risk for arrest and incarceration. "Mr. B" is a pseudonym, and identifying information has been altered in this report to preserve patient confidentiality.

Case Report and Comments

Mr. B was a 38-year-old, divorced Caucasian male with a 20-year history of type I bipolar disorder. Before his hospitalization at UCLA, he was living with his mother in an apartment. Although he previously had worked as an engineer, his illness had led to functional disability and increasing dependence upon his mother. He was being followed on an outpatient basis and was being maintained on a regimen of lithium, 1800 mg/day, and haloperidol, 10 mg/day.

Events leading up to his hospitalization began when his mother noticed him exhibiting manic symptoms, including decreased sleep, rapid speech, and irritability. She suspected that he was not taking his medications. When she questioned him about his compliance, he became hostile and argumentative. The argument escalated and ultimately, Mr. B struck his mother. Concerned for her safety, she left the apartment and went to a local coffee shop. When he followed her to the shop and threatened her, the police were called. When they arrived, Mr. B's mother told them that the perpetrator was her son and that he was mentally ill. She requested that they not arrest him but take him to the hospital for treatment. The police agreed and placed him on a 72-hour hold (section 5150 of the California Welfare and Institutions Code allows for an individual to be hospitalized up to 72 hours for a diagnostic evaluation by a multidisciplinary treatment team). Because he threatened and hit his mother, Mr. B met the criteria for being a "danger to others." Once he was brought to the emergency room, he became extremely agitated and needed to be restrained and sedated with an injection of haloperidol (10 mg), lorazepam (2 mg), and benztropine (2 mg).

The criminalization of the mentally ill begins at the point of arrest. If mental illness seems apparent, a decision must be made by the arresting officer as to whether the individual should to taken to the hospital or jail. In cases where a serious felony has been committed, police are compelled to bring offenders to jail for public safety reasons (9). When the crime is a misdemeanor (as in this case), the decision becomes more complicated. Arrestees may end up in jail or in a hospital, depending on a variety of different factors. Family involvement is one such factor. It was fortunate that the patient's mother was involved in this incident and was able to convince the police that her son needed hospitalization and treatment rather than incarceration.

The proper diversion of a mentally ill arrestee into treatment is critically dependent on the ability of police officers to recognize mental illness in the offender. Police officers do not receive the level of training that mental health professionals do in the diagnosis of mental illness. To the untrained eye, this patient's antisocial behavior could easily be mistaken for that of a criminal rather than someone suffering from mental illness. A study involving a Los Angeles area police department suggested that officers often fail to detect mental illness in arrestees. The study found that while the prevalence of serious mental illness in arrestees is 10%, the majority of police officers surveyed believed that less than 5% of arrestees were mentally ill and in need of treatment (10).

During the early part of his hospitalization, Mr. B was very guarded and hostile toward staff. He denied all manic symptoms when interviewed. Staff observed severe mood lability, minimal sleep, and tangential, disorganized thinking. Eventually, he did report that he had only been sleeping 4–5 hours a night, rather than his usual 8 hours a night, in the weeks preceding his admission. He also expressed ideations that his neighbor was involved in a conspiracy to harm him. In order to manage Mr. B's psychotic mania, his lithium dose was increased to 2400 mg/day, and a regimen of thiothixene was added and titrated to 7 mg h.s. Lorazepam was used on an as-needed basis for episodes of agitation. After 2 days of medication, his manic symptoms improved slightly, and he told staff he wanted to leave the hospital. When the treatment team recommended that he remain in the hospital longer for further stabilization, he became agitated and verbally threatening. He was placed on another involuntary legal hold (section 5250 of the California Welfare and Institutions Code allows for 14 days of additional treatment in a hospital setting after the time set forth by section 5150 expires). He was held on the basis of being a "danger to others" because of his threats and of being "gravely disabled," meaning that because of a mental illness he could not provide food, clothing, and shelter for himself. It was felt that Mr. B met criteria for "grave disability" because he would be homeless, since his mother was not willing to allow his return to the apartment. A legal hearing occurred 6 days after his admission in order to determine if there was "probable cause" to further detain him in the hospital against his will. At the time of the probable cause hearing, the patient had improved minimally but was noted to be compliant with medications. Mr. B assured the court-appointed hearing officer that he was aware of his mental illness and would be involved in outpatient treatment if he were released. Even though the hospital expressed concern that Mr. B would stop his medication when released and quickly decompensate, the request for further involuntary inpatient treatment was denied. The hearing officer indicated that the rationale behind this ruling was Mr. B's acknowledgment of his bipolar disorder, need for medications, and apparent willingness to follow through with outpatient treatment.

Following the closure of many of the nation's state hospitals in the 1960s, there was controversy as how to treat mentally ill individuals who were not willing to accept voluntary treatment. Mental health law at that time was based upon the principals of *parens patrie*, under which the state acts to protect and care for patients. Involuntary commitment criteria were based on a "need for treat-

ment" as determined by their treating physician. Civil rights groups pointed out the abuses that had occurred in state hospitals under this law and advocated for a new law with more stringent commitment criteria and procedural protections before one could be involuntarily committed. This viewpoint prevailed, and most states enacted civil commitment law that was based on the "police powers" principle, the state interest in protecting patients and society from harm. Civil commitment proceedings focused on a patient's dangerousness and were adversarial in nature, pitting physicians against patients in hearings that resembled criminal trials (11).

The new "patient rights-oriented" law made it more difficult for mental health professionals to treat patients involuntarily. The law allowed involuntary treatment of only those who were imminently dangerous to themselves or others or those who were so severely ill and "gravely disabled" that they could not provide themselves with the most basic resources. Thus, the large numbers of patients who did not meet these criteria were "free" to leave treatment if they wished, even though they continued to experience symptoms of their illness.

Upon this decision, Mr. B immediately stated he did not want to remain in the hospital on a voluntary basis and requested a discharge. In stark contrast to his statements to the hearing officer, he refused to take a prescription for lithium, thiothixene, and lorazepam at the time of his against-medical-advice discharge and stated that he had no plans to return for an outpatient follow-up evaluation because he was not mentally ill. After he was discharged against medical advice, Mr. B returned to live in the apartment with his mother, who reluctantly accepted him back because she didn't want him to be homeless. He refused to take medications at home, started drinking, and his psychotic mania progressed.

Fueled by paranoid thinking, Mr. B started an argument with his neighbor that quickly spiraled out of control and turned violent. He took a sledgehammer and began to wave it at his neighbor, who retreated to his house and called the police. Mr. B then poured lighter fluid over the victim's car and threatened to kill the neighbor by "burning him alive." Fortunately, the police intervened before Mr. B was able to follow through on his threats. Police noted Mr. B to be agitated, hostile, intoxicated, and speaking in a disorganized and illogical way. He did not cooperate with police and resisted arrest. He was eventually subdued, handcuffed, brought to jail and booked. A few days later, he was arraigned on the following felony charges: assault with intent to induce bodily injury with a deadly weapon (section 245 of the California Penal Code), attempt to burn property (section 455), and resisting arrest (section 148). At his trial 1 month later, he was sentenced to 90 days in jail and probation in a plea bargain agreement.

A recent study conducted in Los Angeles County at Twin Towers Correctional Facility, the psychiatric division of Los Angeles County jail and part of the community mental health system, suggested that it is common for manic patients to be arrested and jailed shortly after their release from a community hospital. The study examined the treatment history of bipolar patients before their arrest. Of those arrested in a manic state (N=35), 60% had been hospitalized and treated for mania in the month preceding their arrest (12)

This patient's behavior indicated that he was suffering from a frequent, but unfortunate, symptom of major mental illnesses: lack of insight. Insight is best understood as a multidimensional ability that includes the following three components: 1) a realization that one is mentally ill, 2) an attribution of one's symptoms as part of the illness, and 3) acknowledging a need for treatment (2). Approximately 50% of patients with schizophrenia and bipolar disorder have a significant impairment in insight (3). Studies of individuals with bipolar disorder have shown impaired insight to be strongly correlated to noncompliance with treatment, a need for involuntary treatment, and a poor clinical outcome (13–16). A recent study of bipolar patients in treatment demonstrated that a patient's level of illness insight is not fixed and can change over time. Although most patients have some degree of impaired insight during exacerbations of their illness, when these patients are engaged in treatment insight can improve over time. Improvement in insight predicts a good clinical outcome (17).

Unfortunately, mental health law governing the involuntary treatment of patients does not take insight into consideration. In this case, the patient was released from the hospital because he was not found to be "gravely disabled," i.e., his mental illness did not impair him to the degree that he could not survive outside the hospital. With the help of counseling from a patient's rights advocate (an individual who is assigned to advocate for a patient's wishes in civil commitment hearings) and a few days of medications, he was able to appear stable at a brief hearing. He could give the hearing officer the impression that he was not as ill as the treatment staff reported. Although the treatment team felt very strongly that the patient's mania had not been stabilized and that he was in danger of immediate relapse if released, this was not a consideration at the hearing. Current civil commitment laws assume that a patient has full capacity to act in their own best interests when deciding on whether or not to choose treatment voluntarily. The law does not account for the large percentage of mentally ill with impaired capacity, i.e., those who do not recognize they have an illness.

Unfortunately, mentally ill individuals who are readily released from civil settings may go untreated and continue to experience symptoms of their mental illness in the community. Occasionally, behavior stemming from their untreated illness leads to criminal acts, and they enter the criminal justice system. Marc Abramson, a psychiatrist in San Mateo County (in the San Francisco Bay Area), conducted a study that suggested that the implementation of civil commitment law, which allowed patients increased liberty and the ability to refuse treatment, contributed to the increased numbers of mentally ill patients in jails and prisons. In 1969, the Lanterman-Petris-Short Act, California's civil commitment law, was passed, which served as a model for other states that enacted similar re-

forms. In 1970, the year after the Lanterman-Petris-Short Act went into effect, Abramson found that the number of mentally ill inmates entering the criminal justice system doubled and introduced the concept of "the criminalization of the mentally ill" (5).

Initial studies investigating whether mentally ill individuals in the community were more violent than those without mental illness found no significant difference between the two groups (1). These studies, however, were conducted when most mentally ill were sequestered in state hospitals. More recent studies have shown that the mentally ill, as a group, are more violent. In the Epidemiological Catchment Area Study, approximately 12% of those with an affective or schizophrenic disorder reported acting violently in the past year compared with only 2% of those without a mental disorder. Those with a major mental illness and comorbid substance abuse were the most violent individuals in the study: 30% reported a violent act within the preceding year (18). A recent study investigating risk factors for violence found that noncompliance with treatment, active psychotic symptoms, and substance abuse (all present in this patient's case at the time of his assault) are potent predictors of future violent acts among the mentally ill (19). It appears that compliance with treatment significantly reduces the risk that a mentally ill individual will commit a violent crime so that it becomes no greater than those in the population at large (9).

Mr. B was hospitalized at UCLA 4 months after being released on probation. He again was found to be displaying symptoms of psychotic mania and was brought in by a psychiatric emergency team after threatening his mother. He told the treatment staff that when he left jail he had no place to go because his mother would not allow him to live with her. Homeless, he roamed from state to state living a transient lifestyle until he returned to Los Angeles and went back to his mother's apartment. After a few days, his mother recognized she could not manage his agitated behavior and called for help.

During this hospitalization, the court found that Mr. B needed an additional 14 days of treatment because he was homeless and his mother was no longer involved in his care. He stabilized with treatment, and after 17 days, he no longer met criteria for involuntary hospitalization. On the day of discharge, his physician noted a subtherapeutic level of valproic acid despite a dose of 2000 mg/day. Mr. B acknowledged that he had been "cheeking" his medication for 2 days. He was offered voluntarily treatment but refused and was again discharged against medical advice.

A week after his discharge, Mr. B managed to make it to his outpatient follow-up appointment. His speech was rapid, thought process tangential and disorganized, and he was irritable. When he threatened his outpatient psychiatrist with physical harm, security was called, and he was placed in four-point restraints and readmitted to UCLA. This being his third hospitalization within a matter of months, his inpatient treatment staff felt he needed to be placed under a mental health conservatorship so that he could receive long-term involuntary treatment. When he was stabilized, however, the county's public guardian office felt that conservatorship wasn't needed because his mother was willing to care for him in her apartment. Although he took medications during his hospitalization, Mr. B told treatment staff that his diagnosis was "alcohol psychosis" rather than bipolar disorder and that he no longer needed treatment because he did not plan on drinking. He was again discharged to voluntary outpatient care.

This patient's treatment patterns illustrate the development of the "revolving door" some patients get caught in, which was first described by Bachrach in 1982 (20, 21). In Los Angeles County, this is a significant problem. A RAND study (22) showed that of the 106,314 section 5150 admissions (involuntary status) in fiscal year 1997–1998, 51,932 individuals accounted for all of these admissions. Of these patients, 68% were admitted only once, 22% were admitted twice, and 10% were admitted three or more times. Thus, multiple admissions were common (32% of patients), lending support to the "revolving door" phenomenon. Those admitted more than twice had significantly shorter hospital stays (7.7 days compared with the 11.8 days of those admitted two times or less). The 7.7 days is just slightly more than the time used for evaluation and the hearing conducted to pursue longer-term treatment (22). Of greater concern, 19,528 had no prior record of outpatient treatment (23).

In Los Angeles County, there are data to suggest that mentally ill criminal offenders as a group have a significantly different "revolving door" pattern of hospital utilization than do the mentally ill who do not offend. Offending bipolar patients had twice as much inpatient utilization and were hospitalized three times as often, but the length of hospitalization was only half that of nonoffending bipolar patients (12). Conceivably, brief hospital stays result in inadequate treatment, which leads to escalating mania and criminal behavior. Eventually, such individuals end up arrested and incarcerated. Alternatively, offending bipolar patients who refuse treatment may have personality characteristics that place them at risk for criminal behavior.

After discharge, Mr. B was lost to follow-up care at UCLA. His former psychiatrist learned of his whereabouts a year later when contacted by Mr. B's defense attorney. The attorney explained that Mr. B had been arrested 1 month after his last hospitalization at UCLA and was now in a California state prison. He was concerned because Mr. B was not receiving his medication in prison and his condition was worsening. The attorney asked the psychiatrist to write a letter to the court verifying Mr. B's mental diagnosis.

Mr. B's psychiatrist wrote a letter to the judge overseeing his case. The letter expressed concern that Mr. B was not receiving treatment and asked that it be started immediately. It further stated that, in the psychiatrist's view, Mr. B would not benefit from incarceration and needed treatment instead. Release on parole with court-mandated treatment was suggested as the most appropriate way to handle his case.

Discussion

Jails and prisons are not prepared to provide the mental health services for the large numbers of mentally ill that have come under their care. Most criminal justice administrators indicate that jail programs are not equipped to respond effectively to the needs of mentally ill offenders (24). They cite mental health services as one of the most serious institutional service needs. A survey by the National Institute of Justice (25) found that administrators described their mental health programs as "grossly understaffed" and "in urgent need" of program development and of intervention by mental health organizations. A survey of state and federal correctional officers (26) found that 64% of jail administrators indicated need for improved medical services for the mentally ill offender and that 84% of parole and probation officers cite access to mental health professionals as their greatest need. Court-mandated and monitored treatment on probation significantly reduces recidivism in mentally ill offenders (9). However, judges who order mandatory treatment as a condition of probation or parole may often find the resources to provide treatment are not available.

Providing for the large numbers of mentally ill in jails and prisons has placed a financial burden upon the government. A 1995–1996 California-based study estimated that $1.2–$1.8 billion were spent that year arresting, housing, and processing its 11,310 mentally ill inmates through the court system (27). Given the high costs of caring for the mentally ill in the criminal justice system, it is useful to consider what comprehensive mental health coverage for mentally ill patients in the community would cost in comparison.

A study by California's mental health directors found that the cost of providing comprehensive outpatient services to a severely mentally ill person ranges from $7,000–$20,000 per year, depending on how difficult a patient is to treat. The most specialized and intensive outpatient treatment is assertive community treatment, which targets severely mentally ill individuals who are high utilizers of inpatient and emergency services. In these patients, assertive community treatment significantly reduces the number of inpatient hospital days and produces better clinical outcomes than standard community services, and, in the long term, becomes more cost-effective (28, 29). Comprehensive services through assertive community treatment, including housing and social security income, cost society approximately $30,000 in 1994 dollars (30). In the criminal justice system in California in 1994, the cost of providing housing and basic outpatient mental health services to inmates in jail and prison was similarly priced, with estimates ranging from $20,000–$30,000. Care of mentally ill inmates, however, becomes substantially more costly, approximately double the cost of assertive community treatment services, when the additional expenses of legal representation, court costs, and sheriff's and city police departments are considered. Thus, providing for the large numbers of mentally ill in criminal justice institutions appears to misallocate the scarce resources that are available to them (27).

In summary, the mentally ill in the criminal justice system appear to have poor insight regarding their illness, refuse treatment, and cannot be compelled into community treatment under current civil commitment law. Their mental illnesses go untreated and are exacerbated by substance abuse until their behavior, sometimes violent, forces police officers rather than mental health professionals to assume their care. This problem is exemplified by Twin Towers Correctional Facility, which treats mentally ill inmates in the Los Angeles County jail system. With an average daily census of 5,000 patients, it is the largest mental institution in the country (31). Providing care for large numbers of mentally ill in the correctional system is both costly for society and ethically questionable. There exists a need to develop new policies and law aimed at diverting the flow of the mentally ill from the prisons and jails and into treatment settings.

Because there are multiple causes underlying the criminalization problem, changes must occur on many levels. Of paramount importance is reform of civil commitment law. A shift of commitment criteria to focus on "need for treatment" would allow community mental health programs to provide medical care to patients who cannot make rational decisions for themselves because of their inability to recognize their mental illness. Many states have determined that their current mental health law is flawed and are striving to make needed changes. California recently passed legislation allowing a patient's history to be considered in decisions to continue involuntary treatment. A bill currently being considered in California's legislature would allow involuntary hospitalization of patients likely to deteriorate without treatment, which is a commitment criterion several other states have already implemented. Utah, Kansas, and Iowa have mental health laws that incorporate a judicial determination of competence to make treatment decision as part of the civil commitment process. If a patient is unable to rationally weigh the costs and benefits of treatment, their physician makes treatment decisions for them until their competence is restored (32). Other jurisdictions also utilize treatment-oriented approaches. In 1983, England passed the Mental Health Act, which focuses on providing for the "health and safety" of patients and avoids multiple judicial hearings (33).

Further, mentally ill offenders could have their mental illness addressed though the criminal justice system in order to prevent recidivism. Mental health courts can be used to sentence treatment in lieu of a prison or jail sentence. Parole and probation clinics need to have more resources to effectively treat dually diagnosed, noncompliant patients. If different mental health laws and treatment approaches are combined with increased funding for community mental health systems, the "criminalization of the mentally ill" will decline, reducing societal costs but more importantly providing the structured community treatment that patients and their families need.

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