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# MENTALLY ILL PRISONERS IN THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION: STRATEGIES FOR IMPROVING TREATMENT AND REDUCING RECIDIVISM

*W. David Ball\**

## I. INTRODUCTION: CALIFORNIA IS FAILING ITS MENTALLY ILL PRISONERS

Thousands of people with mental illness are currently serving terms in California prisons.<sup>1</sup> These individuals receive inadequate medical and psychiatric care, serve longer terms than the average inmate, and are released without adequate preparation and support for their return to society. As a result, mentally ill offenders are more likely than general-population offenders to violate parole and return to prison. The poor treatment of California's mentally ill prisoners burdens the judicial system, drains the state's budget, and causes needless inmate suffering. Reform of the California correction system's mental health treatment system is both urgent and necessary.

California treats more of the mentally ill inside prison than outside prison. Jails and prisons handle more people with mental illness than hospitals and residential treatment centers combined.<sup>2</sup> 10.5% of California state

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1. For the purposes of this paper, I only consider sex offenders and substance abusers as part of the mentally ill population when these individuals also have an underlying mental illness, and, where noted, when certain statistics include these populations.

2. Stephen Raphael & Michael Stoll, *Why Are So Many Americans in Prison?*, (Berkley Sch. of Pub. Policy, Working Paper, Mar. 2007), available at <http://socrates.berkeley.edu/~raphael/why%20are%20so%20many%20americans%20in%20pri>

prisoners—approximately 16,000—are treated with psychotropic medications, while 12.5% receive in-custody therapy from a trained professional on a regular basis.<sup>3</sup> In fiscal year 2002–03, state-funded (Medi-Cal) residential programs only treated 4778 people with mental illnesses.<sup>4</sup> In the same year, a staggering 197,184 inmates received outpatient mental health services in California jails.<sup>5</sup> A 2005 state report concluded that “jails have become the primary source of treatment for the mentally ill [in California].”<sup>6</sup> The state spends more than \$300 million a year on jail and

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son.pdf (estimating the mentally ill incarcerated population at five times the inpatient population).

3. ALLEN J. BECK & LAURA M. MARUSCHAK, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, *Mental Health Treatment in State Prisons 6* (2001) (reporting 2000 data) [hereinafter BECK BJS STUDY]. These figures are for enrollment in programs, not overall demand. Given the staffing problems in California prisons, discussed *infra* at notes 70–79 and accompanying text, the figures are likely to underestimate demand. Human Rights Watch puts the population of California state prisoners with mental illness at 23,439 as of 2003. HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 18* (2003) [hereinafter HUMAN RIGHTS WATCH, *ILL-EQUIPPED*]. The author notes that this number is a conservative estimate. In the most recent order in the ongoing *Coleman* litigation concerning the California prison system’s mental health care, the Eastern District put the population of mentally ill inmates at 33,000. *Coleman v. Schwarzenegger (Coleman II)*, No. Civ S-90-0520 LKK JFM P, 2007 WL 2122636 (E.D. Cal. July 23, 2007).

4. CAL. DEP’T OF MENTAL HEALTH, *MEDI-CAL TREND REPORT FOR FY 1998–99 THROUGH FY 2002–03* (2003), <http://www.dmh.ca.gov/SADA/SDA-Medi-Cal.asp>. These are unduplicated numbers. That is, they count individuals receiving treatment, not program enrollment.

5. CAL. DEP’T OF MENTAL HEALTH, *INVOLUNTARY DETENTION REPORTS, INVOLUNTARY DETENTIONS IN CAL. FISCAL YEAR 2002–03* (2003), <http://www.dmh.ca.gov/SADA/SDA-Inv-Dtnt.asp>. Residential programs include Adult Crisis Residential and Adult Residential Services. These figures include some duplication, “since the involuntary detention is done on a quarterly basis and this report is summarized by fiscal year . . .” *Id.* at 2.

6. CAL. BD. OF CORR. & REHAB., *MENTALLY ILL OFFENDERS CRIME REDUCTION GRANT PROGRAM: OVERVIEW OF STATEWIDE EVALUATION FINDINGS* (Mar. 2005), [http://www.bdcrr.ca.gov/cppd/miocrg/2005\\_annual\\_report\\_presentation.doc](http://www.bdcrr.ca.gov/cppd/miocrg/2005_annual_report_presentation.doc) [hereinafter 2005 MIOCRG STATEWIDE EVAL.].

probation costs for mentally ill prisoners.<sup>7</sup> Nationally, the situation is equally serious. The rates of mental illness among prisoners are double to quadruple the rate for the U.S. population at large.<sup>8</sup> The U.S. Bureau of Justice Statistics (BJS) estimates that 283,000 of the two million incarcerated people in the U.S. (approximately 16%) suffer from serious mental illnesses, such as schizophrenia, major depression and bipolar disorder.<sup>9</sup>

Prisons are more likely to discipline prisoners with mental illness than inmates in the general population. Inmates with serious illnesses are ill equipped to abide by the myriad rules of prison life, resulting in higher rates of disciplinary action. "While mental illness may not technically violate prison rules, a number of the all but inevitable concomitants of mental illness do."<sup>10</sup> The BJS reported in 2005 that 62.2% of mentally ill state prison inmates had been formally charged with breaking the rules since admission, compared to 51.9% of the general prison population.<sup>11</sup> At the same time, the mentally ill are more vulnerable to physical and sexual

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7. CAL. BD. OF CORR. & REHAB., MENTALLY ILL OFFENDERS CRIME REDUCTION GRANT: ANNUAL REP. TO THE LEGISLATURE 2 (June 2004), [http://www.bdcrr.ca.gov/cppd/miocrg/2004\\_annual\\_report/miocrg\\_2004\\_annual\\_report.doc](http://www.bdcrr.ca.gov/cppd/miocrg/2004_annual_report/miocrg_2004_annual_report.doc) [hereinafter 2004 MIOCRG ANNUAL REP. TO LEGIS.].

8. See PRESIDENT'S NEW FREEDOM COMM'N ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA 2 (2003), <http://mentalhealthcommission.gov/reports/Finalreport/downloads/FinalReport.pdf> (finding that 5% to 7% of adults have a serious mental illness); see also William Kanapaux, *Guilty of Mental Illness*, PSYCHIATRIC TIMES, Jan. 2004, at 1 (finding that U.S. prisoners have rates of mental illness that are up to four times greater than rates for the general population).

9. PAULA M. DITTON, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 2 (1999) [hereinafter DITTON BJS STUDY]. The figure was based on prisoners who either reported a current mental or emotional condition or who had spent at least one night in a mental hospital or treatment program. The figures are higher for women; the study estimates that 24% of female inmates are mentally ill.

10. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 59 (citing aggression, disruptive behavior, and a refusal to follow orders due to an inability to conform one's conduct).

11. DITTON BJS STUDY, *supra* note 9, at 9.

assault, exploitation, and extortion from other inmates.<sup>12</sup> For example, 36% of mentally ill prisoners reported being involved in altercations, compared to 25% of other inmates.<sup>13</sup>

Mentally ill prisoners are also more likely to end up in administrative segregation than general-population inmates, both for punitive reasons (following disciplinary infractions) and protective reasons (following victimization at the hands of fellow inmates).<sup>14</sup> Administrative segregation, in turn, tends to exacerbate (or, in some cases, precipitate) mental illness.<sup>15</sup> Therefore, mentally ill prisoners can find themselves in a vicious circle. Mental illness leads to discipline or victimization problems, which leads to solitary confinement and decompensation.<sup>16</sup> This worsens mental illness and results in further discipline or victimization with further segregation. Mentally ill prisoners suffer these harms for longer periods of time because they serve, on average, fifteen months longer for the same crimes than do the non-mentally ill.<sup>17</sup> Since their illnesses often prevent them from engaging in prison programming that results in the acquisition of “good time” credits, mentally ill prisoners also tend to serve a greater percentage of their sentences.<sup>18</sup>

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12. HUMAN RIGHTS WATCH, *ILL-EQUIPPED*, *supra* note 3, at 56–58. Contributing factors include slower reaction times as a side effect of medication and social isolation from the stigma of mental illness.

13. DITTON BJS STUDY, *supra* note 9, at 9. A New York Correctional Association Study found that 54% of prisoners in intermediate care mental health units reported victimization, “including having property stolen and physical and/or sexual assaults.” HUMAN RIGHTS WATCH, *ILL-EQUIPPED*, *supra* note 3, at 57.

14. HUMAN RIGHTS WATCH, *ILL-EQUIPPED*, *supra* note 3, at 56–59.

15. *Madrid v. Gomez*, 889 F. Supp. 1146, 1216 (N.D. Cal. 1995) (“For some, SHU [secure housing unit] confinement has severely exacerbated a previously existing mental condition, while other inmates developed mental illness symptoms not apparent before confinement in the SHU.” (quoting Grassian Decl. at 4)).

16. Decompensation is “[t]he inability to maintain defense mechanisms in response to stress, resulting in personality disturbance or psychological imbalance.” AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 309 (4th ed. 2000).

17. DITTON BJS STUDY, *supra* note 9, at 8.

18. HUMAN RIGHTS WATCH, *ILL-EQUIPPED*, *supra* note 3, at 126.

California fails its mentally ill prisoners at every step. Prisons fail to adequately screen inmates for mental illness during intake, they fail to offer special programming or housing, they often fail to provide basic treatment, and they fail to address special needs upon release.<sup>19</sup> The result is that mentally ill prisoners get sicker, stay longer, suffer more, and wind up back in prison soon after their release.

These failures have plagued California's prison system for a substantial period of time. In 1995, the federal district court in *Coleman v. Wilson* held that the treatment of the mentally ill in the California corrections system was so inadequate that it violated the Eighth Amendment's prohibition on "cruel and unusual punishment."<sup>20</sup> The *Coleman* court found that the following deficiencies violated the Eighth Amendment: (1) the lack of any screening mechanism for mental illness, (2) inadequate mental health staffing levels, (3) the lack of quality-assurance mechanisms for evaluating mental health staff, (4) delays and denials of medical attention, (5) inappropriate use of punitive measures, and (6) an "extremely deficient" records system.<sup>21</sup> More than ten years later, the same problems continue to plague mental health administration in prison.<sup>22</sup>

The problems with mental health care are symptomatic of problems within California's prison health care system as a whole. Judge Thelton Henderson of the Northern District of California placed the entire prison health care system into receivership in October 2005 in *Plata v. Schwarzenegger*.<sup>23</sup> He described the system as "broken beyond repair" and stated that the

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19. See generally *Coleman v. Wilson*, 912 F. Supp. 1282, 1296 (E.D. Cal. 1995). See also *Coleman v. Schwarzenegger (Coleman II)*, No. Civ S-90-0520 LKK JFM P, 2007 WL 2122636, at \*2-4 (E.D. Cal. July 23, 2007) (screening and treatment); see also *infra* notes 132-140 and accompanying text (release).

20. *Coleman*, 912 F. Supp. 1282. *Coleman* dealt with the mental health system for all prisons except the Pelican Bay supermax prison. *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995), established the unconstitutionality of the level of care at Pelican Bay. See *infra* notes 66-69 and accompanying text.

21. *Coleman*, 912 F. Supp. at 1296-97 (quoting Findings and Recommendations at 61).

22. *Coleman II*, at \*2-4.

23. *Plata v. Schwarzenegger*, CV01-01351, 2005 WL 2932253, at \*1 (N.D. Cal. Oct. 3, 2005).

California Department of Corrections and Rehabilitation (“CDCR”) was “incapable of successfully implementing systemic change.”<sup>24</sup>

California must provide more effective treatment for mentally ill prisoners and prepare for their release in a way that will minimize recidivism. Reforms must focus on the three critical stages in the penal system’s relationship with mentally ill prisoners: intake, living in prison, and release.

## II. INTAKE

During intake, the prison system processes and evaluates prisoners before transferring them to the prisons where they will serve their sentences. Intake begins when prisoners are taken from county jails to one of several state reception centers, such as the California Institution for Men (CIM) and the California Institution for Women (CIW).<sup>25</sup> Prisoners are housed at these reception centers for at least sixty days; however, stays can last as long as several months.<sup>26</sup> Officials at the reception centers screen for any health problems, including mental health problems, and they assess other needs in order to recommend appropriate placement and programming for each inmate.<sup>27</sup> In theory, prisoners transferred from a county jail to a prison should be accompanied by their intake screen, health, and disciplinary records.

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24. *Id.* at \*5.

25. CDCR Facilities Map, Cal. Dep’t of Corr. & Rehab., [http://www.cdcr.ca.gov/Visitors/facilities\\_map.pdf](http://www.cdcr.ca.gov/Visitors/facilities_map.pdf). (last visited Sept. 23, 2007). Other Reception Centers include San Quentin, Wasco State Prison, and North Kern State Prison.

26. There are no good data on the average stay in a reception center, nor are there statutory or judicial mandates limiting the amount of time inmates may spend there. Since placements depend, in part, on the level of overcrowding at destination prisons, time in reception centers is difficult to estimate. North Kern State Prison claims that it “usually” places reception center inmates “within a 60 to 90 day period.” Cal. Dep’t of Corr. & Rehab., North Kern State Prison homepage, [http://www.cdcr.ca.gov/Visitors/fac\\_prison\\_NKSP.html](http://www.cdcr.ca.gov/Visitors/fac_prison_NKSP.html). (last visited Sept. 23, 2007). But in one infamous case, Jon Blaylock, a reception center inmate, murdered Corrections Officer Manuel Gonzalez after six months at a reception center. Cal. State Bd. of Corr., Independent Operations and Incident Review Panel on the Cal. Institutions for Men 3–6 (2005), [http://www.bdcrr.ca.gov/special\\_reports/operational\\_incident\\_review\\_cim/Final%20Report.pdf](http://www.bdcrr.ca.gov/special_reports/operational_incident_review_cim/Final%20Report.pdf). Blaylock was sent to CIM on June 23, 2004, referred for placement on November 19, and was still in the reception center on January 10, 2005. *Id.*

27. See CAL. CODE REGS. tit. 15 § 3075.1 (2006) (outlining the basic process); *Id.* § 3375 (outlining the classification process).

Prisoners are classified according to security risk and placed in prisons with corresponding security levels. Prison officials evaluate each prisoner for the presence of risk factors, each of which is given a numerical weight.<sup>28</sup> The scores for each factor are then added to determine an inmate's classification.<sup>29</sup> However, if certain overriding factors are present, an inmate may be placed in a facility "with a security level which [sic] is not consistent with the inmate's placement score."<sup>30</sup> For example, "an inmate with a history of arson shall not be housed in a facility constructed primarily of wood,"<sup>31</sup> even if his intake score might match the wooden prison's security level. The need for special psychiatric treatment is another such factor; inmates requiring special treatment can be placed in more heavily secured environments than their intake scores would otherwise indicate.<sup>32</sup>

Ideally, diagnoses, programming recommendations, and medications would accompany prisoners as they arrive at reception centers from county jails, but diagnoses, prescriptions, and medications often fail to accompany prisoners at intake.<sup>33</sup> Pursuant to California law, county jails are required to evaluate the mental health of their prison population, but very few of these records are transferred from the jails to the state prison system.<sup>34</sup> Because so few records are transferred, state prison reception centers must administer redundant tests. One study estimated that 30% of all reception center medical screens are needless duplications of county screens, costing up to \$5 million per year.<sup>35</sup> As of January 2007, county jails and the state prison

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28. *Id.* § 3375.3. For example, the inmates are scored according to personal background factors such as age at first arrest, age at incarceration, and length of current sentence, as well as prior incarceration behavior such as disciplinary problems or possession of a deadly weapon. *Id.*

29. *Id.* § 3375.1 (detailing the type of facility where an inmate will be based on the inmate's score).

30. *Id.* § 3375.2(a).

31. *Id.* § 3375.2(a)(3).

32. *Id.* § 3375.2(b)(15).

33. MARCUS NIETO, CAL. RESEARCH BUREAU, HEALTH CARE IN CALIFORNIA STATE PRISONS 17 (1998).

34. *Id.* at 1.

35. *Id.* at 16. These figures are for *all* medical tests, not just those for mental health.



system have not yet worked out an orderly and reliable system for transferring records, even though this failing was identified at least as early as 1995, during the *Coleman v. Wilson* litigation.<sup>36</sup>

California's mental health screening process, developed in response to the *Coleman* lawsuit, is inadequate, notwithstanding court orders to improve it. The current screen is designed to give mentally ill prisoners a "red flag" during intake interviews, a more detailed psychiatric screening seventy-two hours later, and a full psychiatric evaluation within eighteen days.<sup>37</sup> In 2005, however, the *Plata* court found that "the reception center intake process . . . fails to adequately identify and treat the health care problems of new prisoners."<sup>38</sup> Specifically, even though an adequate screen should take at least fifteen minutes to administer, "prisoners' exams in CDCR reception centers typically last no more than seven minutes."<sup>39</sup> Moreover, examinations are unlikely to be accurate because inmates are often screened in groups without regard to confidentiality.<sup>40</sup> Lastly, such screens fail to incorporate objective factors alongside self-reporting; since inmates with acute mental illness are often unable to communicate their symptoms or diagnoses, self-reporting alone cannot adequately determine which prisoners are mentally ill.<sup>41</sup>

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36. *Coleman v. Wilson*, 912 F. Supp. 1282, 1314 (E.D. Cal. 1995).

37. NIETO, *supra* note 33, at 19.

38. *Plata v. Schwarzenegger*, No. C01-01351, 2005 WL 2932253 at \*12 (N.D. Cal. Oct. 3, 2005). Note that this refers to all screens, not just those for mental health. Mental health screens are, however, part of the general health screen administered during prisoner intake.

39. *Id.* Again, this refers to all health screens, not just mental health screens. See also CAL. DEP'T OF CORR. & REHAB., CORRECTIONS STANDARDS AUTHORITY, SUICIDE PREVENTION ASSESSMENT FORM, [http://www.cdcr.ca.gov/Divisions\\_Boards/CSA/](http://www.cdcr.ca.gov/Divisions_Boards/CSA/) (last visited Mar. 5, 2008). A Suicide Prevention Assessment Form provides some insight into the types of questions asked during mental health screens, such as health problems, suicidal ideation, and history of hospitalization. Specifically, the form asks the screener to note signs of depression ("inmate feels hopeless"), psychosis (agitated, responding to voices), the seriousness of criminal charges, and indications of being under the influence of alcohol or drugs.

40. *Plata*, 2005 WL 2932253, at \*13.

41. *Coleman*, 912 F. Supp. at 1305.

Intake screens must also account for co-occurring disorders, including, for example, mental illness coterminous with drug abuse. Co-occurring disorders present particular problems in penal mental health screening because symptoms of mental illness can be masked by or misdiagnosed as the result of drug or alcohol abuse.<sup>42</sup> Screening for drug abuse alongside mental illness is crucial in the penal context. A state study estimated that chemical reactions in the brain—caused primarily by the use of mind-altering drugs—cause major mental disorders in 70% of California prisoners.<sup>43</sup> Nationwide, six in ten mentally ill state prison inmates report being under the influence of alcohol or drugs at the time of their offense.<sup>44</sup> The incidence of violent crime committed by mentally ill prisoners is no greater than that of the general prison population, but the incidence of violent crime by the mentally ill *who also abuse drugs and alcohol* is far greater.<sup>45</sup> Despite these findings, there are few drug treatment programs in county jails, and no drug treatment programs at CDCR reception centers.<sup>46</sup>

The shortcomings of California's intake screens are compounded by their low rate of administration. A national BJS study analyzed mental health screening for prisoners at state-operated facilities, facilities under joint state and local authority, and private facilities at which at least 50% of patients were inmates held for state authorities.<sup>47</sup> This study found that 67.7% of state-operated facilities nationwide (1055 of 1558 facilities) conducted mental health screenings at intake, compared to only 58.1% (50 out of 86) in California.<sup>48</sup> In addition, 63.5% (990 out of 1558 facilities) of national

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42. NAT'L COMM'N ON CORRECTIONAL HEALTH CARE, POSITION STATEMENT: MENTAL HEALTH SERVICES IN CORRECTIONAL SETTINGS (1992), <http://www.ncchc.org/resources/statements/mentalhealth.html>.

43. NIETO, *supra* note 9, at 7.

44. DITTON BJS STUDY, *supra* note 8, at 7.

45. Eric Silver et al., *Assessing Violence Risk Among Discharged Psychiatric Patients: Toward an Ecological Approach*, 23 LAW & HUM. BEHAV. 237, 238 (1999), available at [http://www.springerlink.com/\(a3z4blvb5zk2ze4534j1yr3h\)/app/home/contribution.asp?referrer=parent&backto=issue,5,8;journal,41,138;linkingpublicationresulits,1:104390,1](http://www.springerlink.com/(a3z4blvb5zk2ze4534j1yr3h)/app/home/contribution.asp?referrer=parent&backto=issue,5,8;journal,41,138;linkingpublicationresulits,1:104390,1).

46. NIETO, *supra* note 33, at 1–2.

47. BECK BJS STUDY, *supra* note 3, at 5.

48. *Id.*

facilities conducted psychiatric assessments, compared to only 40.7% (35 out of 86 facilities) in California.<sup>49</sup>

A functional intake process would provide mentally ill prisoners with any necessary care during their stay at reception centers. Early identification of mental illness enables early treatment, which is a hallmark of effective treatment. Early treatment is also constitutionally required. The Eighth Amendment's prohibition against cruel and unusual punishment requires the prison system to provide mental health care "before inmates suffer unnecessary and wanton infliction of pain."<sup>50</sup> Inmates are typically held at reception centers for at least two months, but efforts to increase the number of reception center mental health treatment beds has met stiff local opposition.<sup>51</sup>

Finally, conditions at reception centers must be improved and overcrowding must be reduced. For example, conditions at the CIM's Sycamore Hall are "deplorable," according to a 2005 independent panel investigating the murder of a corrections officer by an inmate.<sup>52</sup> The panel noted "heavy cobwebs, broken windows, fecal matter on the walls, [and] accumulated filth and food on the floor . . . ."<sup>53</sup> The "cramped and dilapidated conditions" have led to operational practices that violate security, and, despite these conditions, "the staff continues to process over 600 inmates per week."<sup>54</sup> The panel recommended that the CDCR "evaluate the number of inmates being processed to determine how many inmates can be safely processed and housed at CIM."<sup>55</sup>

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49. *Id.*

50. *Coleman v. Wilson*, 912 F. Supp. 1282, 1305 (E.D. Cal. 1995).

51. Mason Stockstill, *Chino Prison Mentally-Ill Inmate Plan Reintroduced*, DAILY BULL., Mar. 31, 2006, available at [http://www.dailybulletin.com/news/ci\\_3661249](http://www.dailybulletin.com/news/ci_3661249).

52. CAL. STATE BD. OF CORRECTIONS, INDEPENDENT OPERATIONS AND INCIDENT REVIEW PANEL ON THE CALIFORNIA INSTITUTIONS FOR MEN 12, [http://www.bdcrrt.ca.gov/special\\_reports/operational\\_incident\\_review\\_cim/Final%20Report.pdf](http://www.bdcrrt.ca.gov/special_reports/operational_incident_review_cim/Final%20Report.pdf).

53. *Id.*

54. *Id.*

55. *Id.* at 16.

### III. LIVING IN PRISON

Once prisoners with mental illness are assigned to prisons, they must receive necessary counseling and medication. At a minimum, mentally ill prisoners need to get their prescribed medications regularly. Too often, drug treatment is interrupted when prisoners are transferred between prisons or when lockdown interferes with medication delivery. Prisons should also be responsive to changes in prisoners' mental health and should screen for in-prison onset of mental illness. Finally, special disciplinary procedures, housing, and programming should also be considered in order to improve diagnostic and behavioral outcomes.

Mentally ill prisoners are currently classified into three categories in an attempt to match levels of service to medical needs. The first category, the Correctional Clinical Case Management System (CCCMS), consists of inmates who are capable of living in the general population.<sup>56</sup> CCCMS inmates are prescribed medication and counseling<sup>57</sup> and meet with their clinical case manager at least once every ninety days.<sup>58</sup> The second category, the Enhanced Outpatient Program (EOP), consists of prisoners "who are unable to function or care for themselves" in the general prison population "or who are acutely ill or decompensating."<sup>59</sup> The EOP provides regular medication review, meetings with a case manager at least once a week, and ten hours of structured therapy activities per week.<sup>60</sup> The third category consists of "patients in crisis" who are housed in a Mental Health Crisis Bed in an infirmary on a short-term basis (ten days maximum).<sup>61</sup> Acutely ill patients who continue to remain "in crisis" beyond ten days are transferred to the custody of the Department of Mental Health, which provides residential treatment to prisoners until they are ready to return to prison.<sup>62</sup>

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56. NIETO, *supra* note 33, at 39.

57. *Id.*

58. STEVEN FAMA, ET AL., PRISON LAW OFFICE, CALIFORNIA STATE PRISON HANDBOOK: A COMPREHENSIVE GUIDE TO PRISON & PAROLE LAW 262 (2001).

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

While this classification system could, in theory, be useful in delivering resources where they are most needed, in practice the system fails to deliver adequate care to prisoners in need. The EOP, for example, currently serves 1–2% of the state prison population, falling far short of demand.<sup>63</sup> In 2002, San Quentin's EOP was operating at 385% of capacity, while the Valley State Prison for Women's EOP was at 156% of capacity.<sup>64</sup> Prison policies require transfers into the EOP to be completed within thirty days of a recommendation by medical staff, but "most administrators acknowledge transfers can be delayed far longer . . . ."<sup>65</sup>

Over the past decade, judges in several lawsuits have found that the CDCR's grossly inadequate health care provision violates the Eighth Amendment's prohibition on cruel and unusual punishment.<sup>66</sup> In 1995, two class action suits were filed on behalf of mentally ill prisoners. In *Madrid v. Gomez* the plaintiff class was limited to mentally ill inmates at the "supermax" facility at Pelican Bay,<sup>67</sup> while in *Coleman v. Wilson* the plaintiff class represented mentally ill prisoners in the rest of the prison system.<sup>68</sup> The state lost both suits. As a result, mental health reforms were ordered but not adequately implemented. The CDCR recently lost another suit, *Plata v. Schwarzenegger*, in which the plaintiffs alleged that the provision of prison health care is so grossly inadequate as to constitute cruel and unusual punishment.<sup>69</sup>

The prison healthcare system thus finds itself preparing to be administered through court-supervised receivership. Without addressing the serious and systemic problems with the administration of mental health care, the CDCR

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63. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 98.

64. *Id.*

65. *Id.*

66. See, e.g., HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 164–68; NIETO, *supra* note 33, at 7–8. The grim picture is also substantiated by a number of both state-funded and privately funded studies of the system. See also Little Hoover Commission, Cal. State Gov't Org. & Economy Comm'n, Being There: Making a Commitment to Mental Health 157 (2000), <http://www.lhc.ca.gov/lhcdir/report157.pdf>.

67. *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

68. *Madrid v. Gomez*, 889 F. Supp. 1146, 1214 (N.D. Cal. 1995).

69. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at \*1 (N.D. Cal. Oct 3, 2005).

faces a future of more lawsuits and further judicial control. The prison mental health system must address several problems, including chronic staffing shortages, the lack of quality control and managerial oversight of mental health care providers, an emphasis on security over treatment (which is counterproductive for both security and treatment), a badly outdated and unusable data system, and a dysfunctional medication disbursement system. Correcting these problems will help stabilize the conditions of mentally ill prisoners, which, in turn, will both reduce suffering and improve long-term prognoses.

### A. Staff Shortages

California prisons suffer from inadequate hiring and inadequate retention, each of which contributes to the other. Understaffing drives people from the workforce and high turnover makes recruitment more difficult.

Psychiatric staff levels have been inadequate for decades. The 1995 *Coleman* opinion found not only that current psychiatric positions were understaffed but that several studies for the prior decade had noted shortages as well.<sup>70</sup> A 1998 study found system-wide vacancies of 14% among EOP staff.<sup>71</sup> Pelican Bay State Prison, which houses the CDCR's most incorrigible offenders, opened in December of 1989 without a single psychiatrist on staff.<sup>72</sup> A staff psychiatrist at the California Medical Facility stated that "turnover is huge" and "asserted that the average stay for mental health staff in the prison was a mere six months."<sup>73</sup> Staff shortages extend to the prison health care system as a whole, where some prisons have an 80% vacancy rate for nursing staff.<sup>74</sup> According to one federal district court, the 15% vacancy rate for physicians does not account for "the additional significant percentage of incompetent doctors who need to be replaced."<sup>75</sup>

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70. *Coleman*, 912 F. Supp. at 1306–07.

71. NIETO, *supra* note 33, at 39.

72. *Madrid*, 889 F. Supp. at 1214.

73. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 98. The California Medical Facility in Vacaville is a "centrally-located medical and psychiatric institution for the health care needs of the male felon population in California's prisons." Cal. Dep't of Corr. & Rehab., California Medical Facility homepage, <http://www.cdcr.ca.gov/Visitors/Facilities/CMF.html> (last visited Sept. 23, 2007).

74. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 98.

The remote location of most prisons makes recruitment difficult, as does the low quality of services and the unprofessional environment.<sup>76</sup> Pay is also an issue. Nurses working in the prison system make between 20% and 40% less than they would in the private sector,<sup>77</sup> and 29% less than Medical Technical Assistants, corrections officers who perform duties “that could be performed by licensed nurses . . . .”<sup>78</sup> The pay differential between medical staff and corrections officers has been cited as another barrier to the recruitment of qualified medical staff.<sup>79</sup> Insufficient staff levels not only degrade care, they also increase costs. If no care is available in prison, inmates are sent to hospitals accompanied by corrections officers. The transportation costs alone of sending prisoners to hospitals was \$875 per prisoner per trip in 1998.<sup>80</sup>

### *B. Lack of Quality Control and Management*

Despite ample evidence that prisoners are receiving grossly substandard care, there is very little management or supervision of the provision of medical care. This lack of management makes it almost impossible to fire, retrain, or reassign poorly performing staff.

The court in *Plata v. Schwarzenegger* found that the CDCR “lacks an adequate system to manage and supervise medical care.”<sup>81</sup> There is “a culture of non-accountability and non-professionalism” in the Health Care Services Division (HCSD).<sup>82</sup> In September 2004, the HCSD was ordered to implement quality management of physicians but “failed to come close” to doing so.<sup>83</sup> The system suffers from “operational silo” syndrome, meaning

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75. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at \*11 (N.D. Cal. Oct. 3, 2005).

76. NIETO, *supra* note 33, at 44.

77. *Plata*, 2005 WL 2932253, at \*11.

78. NIETO, *supra* note 33, at 45.

79. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 131.

80. NIETO, *supra* note 33, at 32.

81. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at \*3 (N.D. Cal. Oct. 3, 2005).

82. *Id.* at \*10.

there is no comprehensive, system-wide oversight; rather, there is a series of prisons accountable only to their individual wardens.<sup>84</sup> Further, the CDCR has a staggering 80% vacancy rate in the higher level of management of its HCSD.<sup>85</sup> Receivership is the court's attempt to improve the situation; the medical service workers' union, which is unaffiliated with the prison guards' union, supports receivership.<sup>86</sup>

### C. Inadequate Information Technology

Data management in the HCSD is "practically non-existent,"<sup>87</sup> yet patient treatment, quality control, and management are almost impossible to implement without adequate information. Systems to track patient follow-up do not work,<sup>88</sup> and medical records in most prisons are "either in a shambles or non-existent."<sup>89</sup> Doctors often have to open new patient files because they cannot find existing records.<sup>90</sup> Medical records are not transferred from jails, parole officers, or from other prisons (in the case of inter-prison transfers).<sup>91</sup> Doug Peterson, head of health care at the California State Prison at Sacramento, states that the data deficit is "horrible as a management tool, which affects inmate care. It's harder to monitor whether they're getting what they're supposed to be getting."<sup>92</sup> That is, not only are prisoners not getting the care they need, managers are unable to diagnose

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83. *Id.* at \*2.

84. *Id.* at \*3.

85. *Id.* at \*5.

86. *Id.* at \*33.

87. *Plata v. Schwarzenegger*, No. C01-1351, 2005 WL 2932253, at \*4 (N.D. Cal. Oct. 3, 2005).

88. *Id.*

89. *Id.* at \*14. Indeed, the lack of basic record keeping means that the problem is not just a lack of information technology, but a lack of information gathering itself.

90. *Id.*

91. *See* NIETO, *supra* note 33, at 16.

92. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 102.



which staff should be reassigned. At a minimum, adequate records would help administrators to give prisoners timely access to drugs and treatment.

The CDCR's information technology has been notoriously inadequate for years. In 1992, the CDCR committed itself to the California state legislature to improve health care delivery, standardization, and automation via, *inter alia*, a Health Information Project.<sup>93</sup> CDCR officials later blamed their failure to implement these reforms on the state procurement process.<sup>94</sup> In 1995, *Coleman* noted "extremely deficient" record keeping in the system at large,<sup>95</sup> while *Madrid* described Pelican Bay records as "nothing short of disastrous" and "outrageously disorganized."<sup>96</sup> A 1998 study found that medical records were compiled by hand.<sup>97</sup> In 2004, the Corrections Independent Review Panel, convened by Governor Schwarzenegger and chaired by former Governor Deukmejian, deemed the system's information technology "inadequate."<sup>98</sup>

#### *D. Lack of Coordination with and Cooperation from Corrections Officers*

Corrections officers (COs) are an untapped resource in an area that desperately needs more resources. COs not only administer medications and accompany prisoners to medical clinics, but can also serve as a potential early warning system for changes in prisoners' behavior and mental health. Improvements in mental health treatment would be much easier with cooperation from COs, but, at the very least, COs should not make things worse.

COs currently play too large a role in determining treatment for mentally ill prisoners, making medical decisions based primarily on security considerations. According to Dr. Michael Friedman, director of medical

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93. NIETO, *supra* note 33, at 43.

94. *Id.*

95. *Coleman v. Wilson*, 912 F. Supp. 1282, 1314 (E.D. Cal. 1995) (quoting Findings and Recommendations at 61).

96. *Madrid v. Gomez*, 889 F. Supp 1146, 1203 (N.D. Cal. 1995) (quoting Start Decl. at 89).

97. NIETO, *supra* note 33, at 46.

98. REPORT OF THE CORRECTIONS INDEPENDENT REVIEW PANEL, CAL. PERFORMANCE REVIEW, REFORMING CORRECTIONS 233 (June 2004), <http://cpr.ca.gov/report/indrpt/corr/pdf/from7to11.pdf> (presented to Governor Schwarzenegger).

care at Soledad Prison, “[t]he system . . . is totally corrupted” because “[n]onmedical staff are making medical decisions . . . everything is about security, not about how we look after the inmates.”<sup>99</sup> Because corrections officers have daily contact with inmates, they could provide timely referrals for mental health treatment; however, because COs often fear that prisoners are just faking their symptoms, referrals often are not made until prisoners are grossly psychotic.<sup>100</sup> The *Madrid* decision noted that mentally ill inmates who were not displaying violent or disruptive behavior could remain untreated for “months” despite regular contact with COs.<sup>101</sup> *Madrid* also found that COs tended to impose “a higher referral threshold than appropriate . . . . [C]ustody staff essentially make medical judgments that should be reserved for clinicians, and some inmates are not given appropriate early treatment that could prevent or alleviate a severe psychiatric disorder.”<sup>102</sup> COs are insufficiently trained to make these judgments about treatment. They get a mere three hours of training in “unusual inmate behavior,” which is occasionally supplemented by discretionary programs administered by their local prisons.<sup>103</sup> Medical caregivers also report that COs display a lack of respect for the caregivers, interfering with their ability to make decisions in a clinical context.<sup>104</sup>

While COs are reluctant to refer mentally ill inmates for treatment, they are overly ready to commit mentally ill inmates to administrative segregation. Mentally ill prisoners are disproportionately represented in administrative segregation; in July 2002, 31.85% of the California administrative segregation population was on the mental health caseload.<sup>105</sup> At the Valley State Prison for Women, the figures were even higher; 65.91%

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99. James Sterngold, *Grim Reality of Prison Health Care*, S.F. CHRON., Oct. 16, 2005, at A15.

100. See HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 75–76.

101. *Madrid*, 889 F. Supp. at 1217.

102. *Id.* at 1219.

103. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 77.

104. *Plata v. Schwarzenegger*, C01-01351, 2005 WL 2932253, at \*15 (N.D. Cal. Oct. 3, 2005). Note that this refers to all medical treatment, not psychiatric treatment in particular.

105. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 148.

of the prisoners in secure housing were mentally ill.<sup>106</sup> Mental health care in administrative segregation is limited to drug treatment only. Without therapy, face-to-face contact, and exposure to normal routines, administrative segregation pushes mentally ill inmates towards decompensation. At Mule Creek State Prison, for example, half of the acute-care “crisis beds” came from the EOP administrative segregation population.<sup>107</sup> In other words, mentally ill prisoners who were placed in administrative segregation for protective or disciplinary purposes then decompensated to a point where they required transfers to “crisis bed” treatment.<sup>108</sup> “The requirement of isolation [imposed by administrative segregation] flies in the face of the medically accepted fact that most mentally disordered people need to interact with others.”<sup>109</sup> This treatment creates a cycle in which the mentally ill find themselves “stuck at the bottom”<sup>110</sup> with little chance to leave administrative segregation because “most people in isolation will fall apart.”<sup>111</sup>

Decompensating prisoners, such as those in administrative segregation, sometimes become violent. One defense attorney reported that some seriously mentally ill clients of hers have been “criminally prosecuted for their prison conduct” and that this prosecution “in a number of cases has led to them receiving life sentences under California’s three strikes law.”<sup>112</sup> Fear of decompensating prisoners can make guards overreact, sometimes with horrifying results. *Madrid* cited the example of a mentally ill inmate being placed in hot water long enough to give him severe burns.<sup>113</sup> COs took the prisoner, who was African-American, into the infirmary and said to

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106. *Id.* at 148.

107. *Id.* at 160.

108. *Id.*

109. *Id.* at 155.

110. *Id.* at 154.

<sup>111</sup>HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 149 (quoting Human Rights Watch interview with Sandra Schank, staff psychiatrist, Mule Creek State Prison, California, July 19, 2002).

<sup>112</sup>*Id.* at 66.

<sup>113</sup> *Madrid v. Gomez*, 889 F. Supp. 1146, 1166–67 (N.D. Cal. 1995).

the nurse on duty that it “looks like we’re going to have a white boy before this is through . . . .”<sup>114</sup> After the prisoner was removed from the water, the nurse testified that “from just below his buttocks, his skin had peeled off and was hanging in large clumps around his legs, which had turned white with some redness.”<sup>115</sup> The *Madrid* court concluded that the use of force was not isolated but was “an affirmative management strategy to permit the use of excessive force for the purposes of punishment and deterrence.”<sup>116</sup> The evidence presented “paint[ed] a picture of a prison that all too often uses force, not only in good faith efforts to restore and maintain order, but also for the very purpose of inflicting punishment and pain.”<sup>117</sup>

### *E. Medication’s Problems*

Among other effects, abrupt withdrawal from psychotropic medications can lead to relapses, panic attacks, and psychosis.<sup>118</sup> Yet many prisoners face precisely these terrifying symptoms because the medication delivery system in California prisons is broken. The management of prison pharmacy operations is “unbelievably poor.”<sup>119</sup> At the San Quentin prison, there is “no system” to identify when prescriptions for critical medicines expire.<sup>120</sup> Patients wait two to three weeks for refills, which places many inmates at an unnecessarily increased risk.<sup>121</sup> Delays in distribution of medicine can cause prisoners to lose the mental capacity needed to request medications.<sup>122</sup> Prison policies state that prescriptions must travel with

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114. *Id.* at 1167.

115. *Id.*

116. *Id.* at 1199.

117. *Id.* at 1200.

118. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 118–19.

119. *Plata v. Schwarzenegger*, CV01-01351, 2005 WL 2932253, at \*16 (N.D. Cal. Oct. 3, 2005) (quoting Dr. Puisis).

120. *Id.*

121. *Id.*

122. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 120 (quoting Human Rights Watch interview with J.G. California State Prison, Sacramento, July 18, 2002).

prisoners who are being transferred from one facility to another, but “[i]n practice, however, the prisons do not consistently transfer prescriptions along with the inmates, resulting in large quantities of medication being thrown out rather than administered.”<sup>123</sup> Prescriptions from other prisons are routinely disregarded.<sup>124</sup>

For those prisoners who do get their medications, the system provides disincentives for their use. Side effects to some psychotropic medications are quite substantial,<sup>125</sup> even when taken as directed. However, California has done little to monitor and ameliorate side effects other than those relating to heat sensitivity.<sup>126</sup> Certain medications, for example, induce anxiety as a side effect unless taken just before sleep, yet nighttime deliveries for these medications are not permitted.<sup>127</sup> California also prevents prisoners on psychotropic drugs from participating in work-furlough programs. This creates an incentive for prisoners to discontinue use precisely as they increase contact with society at large.<sup>128</sup> Given that these drugs are medically necessary and readily available outside prison, such a policy is completely nonsensical. Prisoners who opt out of taking drugs cannot be forced to take them without officials following a byzantine process,<sup>129</sup> yet COs and health officials make little effort to convince prisoners who have decided to stop taking their medicine to reconsider.<sup>130</sup>

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123. *Plata*, 2005 WL 2932253, at \*16.

124. *Id.*

125. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 120.

126. *Id.* at 124.

127. *Id.* at 117–18.

128. *Id.* at 120 (identifying potential side effects including “excessive saliva, a powerful clamping of the mouth, severe back and neck cramping, and spasms”).

129. FAMA, ET AL., *supra* note 58, at 265–66 (citing a California court’s holding in *Keyhea v. Rushem*, 223 Cal. Rptr. 746, 755 (Cal. Ct. App. 1986) that “prisoners have the right to a judicial hearing and determination” and requiring the prison to follow specific procedures when any involuntary drugging is undertaken and when officials hope to continue the involuntary drugging beyond seventy-two hours).

130. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 125 (“When prisoners refuse to take their medications, little effort is devoted to coaxing them to change their

These problems are not new. Systemic problems with refill delays, a lack of medication continuity upon transfer, and a failure to monitor side effects were identified as problems as early as 1995 during the *Coleman* litigation.<sup>131</sup>

#### IV. RELEASE

For nearly all mentally ill prisoners, release is inevitable.<sup>132</sup> The CDCR should therefore plan for re-entry of these prisoners as early as possible.<sup>133</sup> Approximately 60,000 prisoners are released in California each year, all of whom are placed on parole.<sup>134</sup> Of these approximately 66,000 parolees, approximately 12,000 have “a documented history of psychiatric problems.”<sup>135</sup> Parole Outpatient Clinics (POCs) provide assistance to 9000

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minds. At most mental health staff may visit a prisoner’s cell front and briefly try to convince him or her to take their medications.”).

131. *Coleman v. Wilson*, 912 F. Supp. 1282, 1309 (E.D. Cal. 1995).

132. JEREMY TRAVIS, *BUT THEY ALL COME BACK: FACING THE CHALLENGE OF PRISONER REENTRY*, xvii (Urban Institute Press 2005) (“[T]he iron law of imprisonment . . . [is] that they all come back. Except for those few individuals who die in custody, every person we send to prison returns to live with us.”).

133. Prison release dates are known with some degree of certainty. Unfortunately, jails do not lend themselves as easily to careful release planning, because so many mentally ill inmates are there as a part of pretrial detention, either because they have failed to post bail or because they pose a danger to the community. Accordingly, many mentally ill inmates are released from jail with little or no advance notice, either as a result of posting bail or as a result of getting credit for “time served” at an arraignment.

134. The 2001 report, using data from 2000, states that there were 56,000 people released into parole. See California Prisoners and Parolees (2001), [http://www.cdcr.ca.gov/Reports\\_Research/Offender\\_Information\\_Services\\_Branch/Annual/CalPris/CALPRISd2001.pdf](http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/CalPris/CALPRISd2001.pdf).

135. CAL. STATE LEGIS. ANALYST’S OFFICE, *ANNUAL ANALYSIS OF BUDGET BILL, JUDICIARY & CRIMINAL JUSTICE: LINKING MENTALLY ILL OFFENDERS TO COMMUNITY CARE* D-14-15 (2000), [http://www.lao.ca.gov/analysis\\_2000/crim\\_justice/cj\\_2\\_cc\\_mentally\\_ill\\_anl00.html\\_1](http://www.lao.ca.gov/analysis_2000/crim_justice/cj_2_cc_mentally_ill_anl00.html_1). Data are somewhat difficult to come by, since the state changed parole databases within the last five years. A 2004 study commissioned by the CDCR provides another estimate: 48,291 parolees were under some sort of mental health supervision between July 2001 and December 2003, for an average of 19,316 per year (of whom 79.8% were CCCMS, 14.2% EOP, and 6% unclassified). See NEUROPSYCHIATRIC INST., UNIV. OF CAL., LOS ANGELES, *THIRD ANNUAL REPORT ON THE*

of these individuals.<sup>136</sup> If intake diagnoses prisoners' mental illnesses and the prison sentence treats them, release should prepare prisoners to treat their condition outside prison and, one hopes, avoid further incarceration. Recidivism can be reduced if re-entry is planned, if intervention is front-loaded, and if parole officers embrace the harm reduction principle (a public-health-oriented rather than criminal-justice-oriented approach to dealing with parole infractions). Investments in release programs should ultimately generate a virtuous cycle; when prisoner recidivism decreases, more resources are freed for treatment within the prison system and within non-penal mental health institutions.

The most effective post-release programs follow the integrated services model, concentrating on the period immediately following release and coordinating multiple services such as mental health, parole, therapeutic treatment for drug and alcohol addiction, housing, and employment.<sup>137</sup> For example, prisoners about to be released should have an adequate supply of medication (at least seventy-two hours' worth), some form of housing, and contacts with a coordinated team of correctional and social services staff. Such efforts will aid the recently-released prisoners as they enter parole, seek permanent housing, pursue job training and employment, enroll in drug and alcohol abuse counseling, and receive restored government benefits such as Temporary Aid to Needy Families, Medi-Cal, Medicaid, Social Security, and State and Social Security Disability Insurance.<sup>138</sup> Treatment should

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MENTAL HEALTH SERVICES CONTINUUM PROGRAM OF THE CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION—PAROLE DIVISION 14 (2005) [hereinafter 2005 ANNUAL MHSCP REPORT].

136. 2005 ANNUAL MHSCP REPORT, *supra* note 135, at 14. These numbers must be taken with a grain of salt; sex offenders are required to report to POCs, even if they are at low risk of reoffending. Assuming that the released prisoners reflect the general incidence of mental illness found in the prison population—10.5%, to use the most conservative estimate—this means that almost 7,000 prisoners with serious mental illnesses will be released on average per year. According to a 2004 report, parolees released from the EOP program are given highest priority for treatment, followed by those from Mental Health Crisis Beds, inmates released from the Department of Mental Health (e.g. inmates from the CONREP program), and inmates classified as CCCMS. *Id.* at 8.

137. Milton Marks, "LITTLE HOOVER" COMM'N ON CAL. STATE GOV'T ORG. & ECONOMY, Rep. No. 172, BACK TO THE COMMUNITY: SAFE & SOUND PAROLE POLICIES, x (2003), available at <http://www.lhc.ca.gov/lhcdir/report172.html> [hereinafter LITTLE HOOVER].

employ cognitive behavioral techniques, emphasize positive reinforcement, use actuarial (population-based) assessments of risk, and be based in the community.<sup>139</sup> It is not enough to threaten to be “tough” on parolees, particularly those with mental illnesses, because threats “do not target for change the known predictors of recidivism.”<sup>140</sup>

Some release programs for mentally ill prisoners have shown promising results, but, system-wide, too many mentally ill parolees are returning to prison. And too many of those are returning for reasons unrelated to the commission of new crimes. According to a national 2002 study, 22% of parolees self-reported that their parole was revoked for failure to report, 16% said their parole was revoked for drug violations, and 18% reported other reasons such as failure to meet financial or employment conditions.<sup>141</sup> In San Francisco, a staggering 94% of mentally ill offenders on parole have their parole revoked and are returned to prison.<sup>142</sup> Ironically, more intense supervision without treatment has been shown to lead to higher rates of revocation, but when more supervision is coupled with treatment, recidivism has been shown to drop 20–30%.<sup>143</sup> A zero-tolerance policy for illegal drug use could be the common thread; parolees need treatment, not just supervision, if they are to avoid relapses into drug abuse.<sup>144</sup>

The CDCR should aim to reduce parole revocations that are a function of untreated mental illness, with an understanding that this focus in no way jeopardizes its mission to protect public safety. A number of legal mechanisms already give parole officers the authority to send dangerous

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138. Mentally ill prisoners report high rates of homelessness, unemployment, and drug use prior to incarceration. DITTON BJS STUDY, *supra* note 9, at 5.

139. Joan Petersilia, *What Works in Prisoner Re-Entry: Reviewing and Questioning the Evidence*, FED. PROBATION, Sept. 2004, at 3–4, available at [http://uscourts.gov/fedprob/September\\_2004/whatworks.html](http://uscourts.gov/fedprob/September_2004/whatworks.html).

140. *Id.* at 4.

141. JOAN PETERSILIA, WHEN PRISONERS COME HOME: PAROLE AND PRISONER REENTRY 149 (Oxford Univ. Press 2003); *see also* SONJA SHIELD, CTR. ON JUVENILE AND CRIMINAL JUSTICE, ADDRESSING GAPS IN POST-RELEASE SERVICES FOR MENTALLY ILL OFFENDERS: ONE COMMUNITY'S RESPONSE 4 (2003), [http://www.cjcj.org/pdf/mentally\\_ill.pdf](http://www.cjcj.org/pdf/mentally_ill.pdf).

142. SHIELD, *supra* note 141, at 2.

143. PETERSILIA, WHEN PRISONERS COME HOME, *supra* note 141, at 84.

144. SHIELD, *supra* note 141, at 5.



mentally ill parolees back to prison. As the standard form for conditions of parole states,

[w]hen the Board of Prison Terms determines, based upon psychiatric reasons, that you pose a danger to yourself or others, the Board may, if necessary for psychiatric treatment, order your placement in a community treatment facility or state prison or may revoke your parole and order your return to prison.<sup>145</sup>

Parolees can be temporarily returned to prison under an “Emergency Transfer” if they meet the criteria for mental illness and if they “cannot receive necessary psychiatric treatment pending a hearing.”<sup>146</sup> Parole officers are required to report to the Parole Board if a parolee’s mental condition deteriorates “such that the parolee is likely to engage in future criminal behavior.”<sup>147</sup> Parolees must then be returned to prison upon a finding of future criminal behavior. Finally, a parolee can be returned to prison if he or she has a mental disorder that “substantially impairs his or her ability to maintain himself or herself in the community” and “necessary psychiatric treatment cannot be obtained in the community.”<sup>148</sup>

As an alternative to parole, prisoners with acute mental illness should continue to be released into treatment through the Mentally Disordered Offender (MDO) program. A prisoner is classified as an MDO if (1) he or she has a severe mental disorder that is not in remission, (2) the disorder was either one of the causes of or an aggravating factor in a crime involving force or violence, and (3) he or she poses a substantial danger of physical harm to others.<sup>149</sup> When an MDO’s prison term expires, he or she is released into inpatient treatment at a state mental hospital as a condition of parole.<sup>150</sup>

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145. FAMA, ET AL., *supra* note 58, at app. 10-10-A.

146. CAL. CODE REGS. tit. 15 § 2605(c) (2006).

147. *Id.* § 2616(a)14.

148. *Id.* § 2637(b)6. Note, however, that the legality of the portions of § 2637 that apply to sexually violent predators is in dispute. A California state Court of Appeals held that it is a violation of due process to hold a prisoner beyond his release date based solely on a finding that he has a mental disorder and is in need of treatment. See *Terhune v. Superior Court*, 65 Cal. App. 4th Supp. 864 (Cal. App. Dep’t Super. Ct. 1998).

149. CAL. PENAL CODE §§ 2960-2981 (West 2000).

150. FAMA, ET AL., *supra* note 53, at 407.

The MDO program provides flexibility in the treatment of mentally ill offenders once they are released from prison. MDOs can be treated on an inpatient basis for the duration of parole. If, at the end of parole, an MDO continues to have severe mental disorders, and if these disorders are not in remission or cannot be kept in remission without treatment, or if the MDO continues to pose a substantial danger of physical harm to others,<sup>151</sup> the Department of Mental Health (DMH) can refer the case to the local District Attorney, who will then initiate proceedings for civil commitment.<sup>152</sup> If an MDO can be safely and effectively treated on an outpatient basis, however, the DMH will recommend treatment in the Conditional Release Program (CONREP).<sup>153</sup> CONREP provides full mental health services, including individual and group therapies, substance abuse screenings, and psychological assessments.<sup>154</sup> Participants who do not comply with their CONREP treatment plans can be returned to state hospital inpatient status.<sup>155</sup>

California should ultimately take a few programs and implement them statewide, or expand existing grant-making programs so that local jurisdictions receive funding for the programs they develop. In either case, the state should require regular reports on parolee outcomes from local jurisdictions. More information is necessary to diagnose shortcomings and to shift managerial and material resources to where they are most needed. The following programs demonstrate some of the key features of a successful post-release approach, although none operate on the scale necessary to meet the statewide demand.

*A. The Mental Health Services Continuum Program: Transition from Prison to Parole*

The Mental Health Services Continuum Program (MHSCP) is a statewide program designed to ease mentally ill inmates' transition from prison to

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151. CAL. PEN. CODE § 2970. *See also* *People v. Beeson*, 99 Cal. App. 4th 1393 (Cal. Ct. App. 2002) (describing an MDO commitment proceeding).

152. FAMA, ET AL., *supra* note 58, at 411.

153. CAL. WELF. & INST. CODE § 4360 (West 1998).

154. Cal. Dep't of Mental Health, Forensic Conditional Release Program (CONREP), [http://www.dmh.cahwnet.gov/Services\\_and\\_Programs/Forensic\\_Services/CONREP/default.asp](http://www.dmh.cahwnet.gov/Services_and_Programs/Forensic_Services/CONREP/default.asp) (last visited Mar. 2, 2008).

155. *Id.*

parole and thereby reduce recidivism.<sup>156</sup> It serves parolees released on or after October 1, 2000.<sup>157</sup> The program aims to assess inmates' pre-release needs, assist with eligibility and applications for public assistance, provide enhanced post-release mental health treatment, improve continuity of care from prison to the community, assist participants with re-integration into the community, and standardize care across all four of California's parole regions.<sup>158</sup>

Social workers under the aegis of the regional Transitional Case Management Program coordinate the care of program participants, beginning with an in-prison face-to-face assessment within ninety days of the inmate's Earliest Possible Release Date (EPRD).<sup>159</sup> The assessment is then updated within thirty days of the EPRD and the information is entered into the Parole Automated Tracking System database.<sup>160</sup> A first post-release appointment is also scheduled within three business days for EOP parolees and seven business days for stable, functioning CCCMS parolees.<sup>161</sup>

A 2005 study of MHSCP participants from July 1, 2001 to December 31, 2003 showed promising results.<sup>162</sup> Participants in the program were much more likely than non-participants to attend Parole Outpatient Clinics (POCs) and less likely to return to prison.<sup>163</sup> Pre-release assessment alone appeared to be an important factor in improving post-release POC attendance: 66.2% of assessed inmates attended at least one POC session, compared to 50.8%

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156. 2005 ANNUAL MHSCP REPORT, *supra* note 135, at 1.

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.* at 1–2. Again, Enhanced Outpatient Program (“EOP”) parolees are diagnosed with acute onset of a serious mental disorder with delusional thinking, hallucination, etc. FAMA ET AL., *supra* note 58, at 262. Correctional Clinical Case Management System (“CCCMS”) parolees are diagnosed with mental illness but stable functioning. *See supra* notes 56–62 and accompanying text.

162. 2005 ANNUAL MHSCP REPORT, *supra* note 135, at 2 (observing that “the percentage of inmates who are assessed has increased over time”).

163. *Id.*

of non-assessed inmates.<sup>164</sup> Assessed inmates also attended more POC sessions, on average, than non-assessed inmates did, a mean of 4.4 versus 3.3.<sup>165</sup> Most significantly, pre-release assessments were associated with a 19% reduction in the likelihood of being returned to custody in the first twelve months of release, and having at least one POC contact was associated with a 37% reduction in recidivism risk.<sup>166</sup> The 2005 study estimated that cost savings from the program are substantial. Based on reduced incarceration days, pre-release assessments save \$2,194 for each EOP parolee and \$712 for each CCCMS parolee.<sup>167</sup> Parolees attending at least one POC session saved the CDCR \$5998 per EOP parolee and \$3224 per CCCMS parolee.<sup>168</sup>

MHSCP's main shortcoming is that the program does not reach all eligible prisoners. Recent statistics show that only 57% of the eligible pool of released prisoners were assessed in a face-to-face meeting prior to release.<sup>169</sup> The earlier an inmate appears on the Offender Information Services (OIS) list of soon-to-be-released inmates, the more likely he or she will be assessed face-to-face.<sup>170</sup> 63.5% of MHSCP-eligible inmates appearing on the OIS list more than forty-five days before their release date were assessed face-to-face.<sup>171</sup> But only 17.8% of MHSCP-eligible inmates who appeared on the OIS list within forty-five days of release got a face-to-face assessment.<sup>172</sup> Assessment rates have been improving recently,<sup>173</sup> but it

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164. *Id.*

165. *Id.*

166. *Id.* at 3.

167. *Id.*

168. 2005 ANNUAL MHSCP REPORT, *supra* note 135, at 3.

169. *Id.* at 2 (observing that "the percentage of inmates who are assessed has increased over time").

170. *Id.*

171. *Id.*

172. *Id.*

173. *Id.* at 2.

remains to be seen whether the program can continue to reach more and more prisoners.

*B. Mentally Ill Offender Crime Reduction Grant Programs*

In 1998, the California Legislature authorized the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program to fund innovative local programs targeting mentally ill offenders.<sup>174</sup> MIOCRG currently provides more than \$80 million to thirty projects in twenty-six of California's fifty-eight counties.<sup>175</sup> To set the program's priorities, county service providers and law enforcement officials were asked what resources they needed to accommodate returning mentally ill offenders. Their responses included (1) better prison discharge planning, (2) more housing options, (3) increased treatment capacity, and (4) interagency coordination.<sup>176</sup> The MIOCRG programs are funded with those priorities in mind.

Though the funding is disbursed at the state level, all MIOCRG programs are administered at the county level. The state encouraged counties to experiment with various forms of collaborative programs as a means of learning which approaches are most effective in decreasing recidivism among the mentally ill.<sup>177</sup> Because mental health services are provided through counties, local administration allows community stakeholders a greater opportunity to coordinate care. Two-thirds of county programs draw on the Assertive Community Treatment (ACT) model,<sup>178</sup> in which a multidisciplinary group of providers services clients as a team and is available around the clock. A study aggregating data from ACT programs showed positive results.<sup>179</sup> Participants scored higher on the improved Global Assessment of Functioning (GAF) Scale, a common psychiatric assessment tool that measures social, psychological, and occupational

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174. CAL. PEN. CODE § 6045 (West 2000).

175. 2005 MIOCRG STATEWIDE EVAL., *supra* note 6, at 1.

176. 2004 MIOCRG ANNUAL REP. TO LEGIS., *supra* note 7, at 4.

177. *Id.* at 1.

178. 2005 MIOCRG STATEWIDE EVAL., *supra* note 6, at 1. ACT criteria include multidisciplinary staffing, integration of services, low client-staff ratios, and twenty-four hour access. *Id.*

179. 2004 MIOCRG ANNUAL REP. TO LEGIS., *supra* note 7, at 3.

functioning.<sup>180</sup> The strategies common to the most successful programs were interagency collaboration, intensive case management, assistance in securing housing and government benefits, use of a common center or clinic, assistance with transportation, and peer support for participants.<sup>181</sup>

Unfortunately, most counties exclude offenders sentenced for violent crimes from their MIOCRG programs.<sup>182</sup> This makes little sense. No county program needs to account for any mentally ill parolee who is currently dangerous. Any offender who is still violent will be treated under existing programs for Mentally Disordered Offenders or the Conditional Release Program.<sup>183</sup> Ex-offenders who were sentenced for violent crimes but who are not currently dangerous need treatment to ensure that they remain non-violent. In short, offenders with violent criminal histories will not go away or spontaneously heal themselves; ignoring the problem will not eliminate it. Denying these offenders care does not make the public safer but, instead, increases the likelihood of relapse and a return to prison, at greater societal expense.<sup>184</sup>

### C. Programs Targeting the Mentally Ill Homeless

California has targeted the mentally ill homeless through a variety of state initiatives, commonly referred to as “AB 2034 programs” after State Assembly Bill 2034, passed in 2000.<sup>185</sup> AB 2034 programs serve, but do not specifically target, ex-offenders among the homeless mentally ill population, although a “large number” of participants come “directly out of jail or prison.”<sup>186</sup> Over three years, participants in AB 2034 pilot programs reduced days spent in incarceration by 72.1% and the number of

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180. *Id.* at 4.

181. *Id.* at 7. Many of these factors track closely with the ACT criteria; *see id.* at 1.

182. 2005 MIOCRG STATEWIDE EVAL., *supra* note 6, at 2.

183. *See supra* notes 138–43 and accompanying text.

184. *See supra* notes 137–44, 156–73 and accompanying text (recidivism); *see also infra* notes 201–03 and accompanying text (cost savings).

185. STEPHEN MAYBERG, EFFECTIVENESS OF INTEGRATED SERVS. FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS, at i (2003), [http://www.dmh.cahwnet.gov/Prop\\_63/MHSA/docs/resource\\_listings/AB2034\\_may2003.pdf](http://www.dmh.cahwnet.gov/Prop_63/MHSA/docs/resource_listings/AB2034_may2003.pdf).

186. *Id.* at 8.

incarcerations by 45.9%.<sup>187</sup> Participants' ability to secure housing was a foundation for successful treatment. "What has become apparent to most providers and stakeholders is the therapeutic significance of having a stable place to live, and the foundation this provides for individuals' ability and desire to make progress in other aspects of their lives."<sup>188</sup>

AB 2034 programs also treat co-occurring substance abuse: 61.9% of program participants had a co-occurring substance abuse disorder.<sup>189</sup> The results of the test programs show "that to be effective it is necessary to treat the mental illness and the substance abuse issues simultaneously rather than separately."<sup>190</sup> The program also emphasizes the importance of collecting data, particularly for outcome-based assessments of effectiveness.

The requirements for data collection and reporting . . . send a universal message to all . . . that what we care about is not limited to what type of mental health service someone is receiving, but rather where people are living, whether they are working, avoiding incarcerations and inappropriate hospitalizations, and generally improving the quality of their lives.<sup>191</sup>

Outcome measurements for programs include current housing and employment, which is an outcome focus unique to this program.<sup>192</sup> As of 2003, AB 2034 programs served 5000 people, about 10% of the estimated 50,000 mentally ill homeless people in California.<sup>193</sup>

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187. *Id.* at 10.

188. *Id.* at 2.

189. *Id.* at 8.

190. *Id.*

191. STEPHEN MAYBERG, EFFECTIVENESS OF INTEGRATED SERVS. FOR HOMELESS ADULTS WITH SERIOUS MENTAL ILLNESS, at 22 (2003), [http://www.dmh.cahwnet.gov/Prop\\_63/MHSA/docs/resource\\_listings/AB2034\\_may2003.pdf](http://www.dmh.cahwnet.gov/Prop_63/MHSA/docs/resource_listings/AB2034_may2003.pdf). Note that the importance of collecting data is addressed to providers of the services. The message of data's importance "resounds from line staff to program administrator, from county mental health director to State mental health director, from the Legislature to the Governor." *Id.*

192. *Id.*

193. *Id.* at 36.

#### D. Graduated Sanctions and Harm Reduction

One San Francisco program funded by AB 2034 uses graduated sanctions within a harm reduction philosophy, recognizing that abstinence from drug use is the ultimate goal while “accept[ing] that not everyone is ready or able to cease all drug use immediately.”<sup>194</sup> Under harm reduction, drug abuse is treated according to a disease model, not a criminal one. When a client relapses, the graduated sanctions approach allows administrators to respond by adjusting treatment first, rather than immediately revoking parole.<sup>195</sup> As one program administrator says, “everyone agrees abstinence is the ideal. But that is not going to happen, so let’s not make them flee from treatment[.]”<sup>196</sup>

One method of getting patients to reduce dependence on illegal drugs is to educate them about symptom management and about the benefits of legal medications.<sup>197</sup> The theory behind this policy is that many mentally ill homeless self-medicate through the use of illegal drugs and will make healthier decisions if they are better informed. Program administrators also build bridges to the criminal justice system, “which increases the likelihood that judges will release clients to treatment programs, or probation officers will defer to case managers [sic] treatment recommendations.”<sup>198</sup>

California’s official parole policies must be amended if harm reduction and graduated sanctions are to be rolled out on a large-scale basis. Parole officers are currently constrained by regulations and policies in their ability to participate in such programs, because officers are still officially required to report certain offenses.<sup>199</sup> Parole officers are also hindered by the prospect of legal liability, which affects their willingness and ability to bend the rules for a given client.<sup>200</sup> State indemnification of parole officers who participate in certain programs might improve treatment outcomes.

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194. SHIELD, *supra* note 141, at 5.

195. *Id.* at 7.

196. *Id.* at 6.

197. *Id.* at 6–7.

198. *Id.* at 8–9.

199. *Id.* at 10; *see, e.g.*, CAL. CODE REGS. tit. 15 § 2616 (2006).

200. PETERSILIA, WHEN PRISONERS COME HOME, *supra* note 141, at 85–86.



Savings from implementing graduated sanctions could pay for indemnification.<sup>201</sup> The 2003 Little Hoover report on parole recommended both graduated sanctions and shorter revocation sentences as a way of cutting costs “without jeopardizing public safety.”<sup>202</sup> Treating drug abuse with graduated sanctions was estimated to save \$151 million immediately, while reducing the average revocation sentence from 140 days to 100 days was estimated to save \$300 million per year.<sup>203</sup>

## V. POLICY RECOMMENDATIONS

Without a change in the culture of the CDCR health care system, policy recommendations are meaningless. The problems with California prison health care in general, and mental health care in particular, are both well documented and well entrenched. No policy recommendation has the power to reform the system. Any attempt to fix the unconstitutional and embarrassing state of the prison mental health care system must begin by repairing the system’s culture of failure. Once the CDCR’s culture of failure is replaced with accountability and responsibility, the state must implement several specific changes: (1) some form of diversion from the penal system; (2) flexible, fully-funded, coordinated provision of care in prisons, including information systems and managerial oversight designed to ensure compliance with standards of care; (3) an expansion of programs targeting the mentally ill and specific subgroups therein; and (4) an expansion of post-release programs as outlined above.

### A. Promote Alternatives to Prison

Because people with mental illness tend to do poorly in prison,<sup>204</sup> all efforts should be made to divert them from incarceration where practical. These efforts should include implementation of programs encouraging diversion from the criminal justice system, expansion of treatment resources outside the penal context, and, perhaps most radically, treatment of mental illness as a public health problem regardless of whether the person with mental illness is in prison or not.

Diversion saves money and improves outcomes. California can either spend taxpayers’ money incarcerating the mentally ill or spend the

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201. LITTLE HOOVER, *supra* note 137, at iii.

202. *Id.*

203. *Id.* These figures are for parolees in general, not just mentally ill parolees.

204. See *supra* notes 10–18 and accompanying text.

same amount to serve more patients more effectively in a non-penal context. Whenever the mentally ill come into contact with the criminal justice system, diversion should always be an option. Police should be trained to de-escalate conflicts with the mentally ill and should be encouraged to refer the individuals they encounter to the Department of Mental Health (DMH). Furthermore, 911-emergency dispatchers should also send trained mental health professionals to respond to calls believed to have a mental health component.<sup>205</sup> Before trial, courts should consider diverting mentally ill defendants from prosecution into treatment, or from criminal court to a mental health court.<sup>206</sup> Mental health courts in particular, by combining law enforcement and social services in a therapeutic approach, have proven particularly effective.<sup>207</sup> According to the California court system, as of 2002, thirteen trial court systems had established mental health courts,<sup>208</sup> additional courts will be funded as a result of Proposition 63.<sup>209</sup>

Non-penal forms of mental health treatment must receive greater resources than they do now if diversion is to work. "The non-penal mental health infrastructure has shrunk dramatically over the past 50 years."<sup>210</sup> California's mental health treatment system began to atrophy during the 1950s, when the deinstitutionalization movement proposed to treat people with mental illness in the least restrictive setting.<sup>211</sup> From 1955 to 1994, the population of mentally ill patients in California state hospitals dropped

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205. See COUNCIL OF STATE GOV'TS, CRIMINAL JUSTICE/MENTAL HEALTH CONSENSUS PROJECT, 36-38 (2002), [http://consensusproject.org/downloads/Entire\\_report.pdf](http://consensusproject.org/downloads/Entire_report.pdf).

206. See *id.* at 82-89.

207. *Id.* at 88.

208. JUDICIAL COUNCIL OF CAL., MENTAL HEALTH COURTS: OF CURRENT INTEREST (2007), <http://www.courtinfo.ca.gov/programs/collab/mental.htm>.

209. See *infra* notes 220-26 and accompanying text.

210. E. Fuller Torrey & Mary T. Zdanowicz, *Deinstitutionalization Hasn't Worked*, WASH. POST, July 9, 1999, at A29 ("[W]e have lost effectively 93 percent of our state psychiatric hospital beds since 1955.").

211. See generally E. FULLER TORREY, *OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS* 34 (John Wiley & Sons, Inc. 1997).

89.8%.<sup>212</sup> Adjusting for the boom in California's population over that time and assuming steady rates of mental illness, the current inpatient population is 96% smaller than it was in 1955.<sup>213</sup> In other words, 96% of people who would have received inpatient treatment in state mental hospitals in 1955 must now turn elsewhere.<sup>214</sup> Where do they go?

Some observers refer to the "balloon theory" of mental illness treatment—that is, by pushing down on one part of the balloon, i.e., reducing hospitalization, the needs of people with mental illness merely arise in a different location, i.e., prison.<sup>215</sup> Untreated mental illness may manifest itself in behavioral problems that result in arrest and imprisonment,<sup>216</sup> and often, the only treatment available is in jail. Anecdotal reports indicate that judges sometimes put the mentally ill in prison to give them access to mental health services.<sup>217</sup> This might explain why extreme recidivism among inmates (those inmates with eleven or more prior offenses) is twice as high for the mentally ill.<sup>218</sup> Ironically, a deinstitutionalization policy borne of a desire to treat the mentally ill using the least restrictive alternative now places them in the most restrictive environment possible.<sup>219</sup> Ultimately,

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212. *The New Asylums, Deinstitutionalization: A Psychiatric Titanic*, FRONTLINE, 2005, <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html> (citing generally TORREY, *supra* note 211).

213. *Id.*

214. *Id.*

215. See Raphael & Stoll, *supra* note 2, at 46 (citing Lionel Penrose, "Mental Disease and Crime: Outline of a Comparative Study of European Statistics," 18 BRIT. J. MED. PSYCHOLOGY 1 (1933)). Raphael and Stoll are skeptical of this theory, however, citing the different demographics of the deinstitutionalized population and the inmate population. *Id.* at 47–49.

216. Kanapaux, *supra* note 8, at 2.

217. See *id.* at 6; see also *The New Asylums, Some Frequently Asked Questions*, FRONTLINE, 2005 <http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faq.htm> (quoting Reginald Wilkinson, head of the Ohio prison system: "I've actually had a judge mention to me before that, 'We hate to do this, but we know the person will get treated if we send this person to prison.'").

218. See *The New Asylums, Some Frequently Asked Questions*, *supra* note 217.

219. This phenomenon—the transition from inpatient treatment in hospitals to incarcerated treatment in prisons—is known as transinstitutionalization. See Ralph

diversion into treatment will work only if greater resources are devoted to non-penal alternatives.

Money generated by various state and federal initiatives may be a path to obtain greater resources for mentally ill offenders. Proposition 63, passed by California voters in November 2004 and codified as the Mental Health Services Act (MHSA), raises money for the treatment of the mentally ill via a tax on Californians with incomes exceeding \$1 million.<sup>220</sup> The MHSA provides funding in excess of \$600 million a year,<sup>221</sup> equivalent to a 26% increase over current funding levels.<sup>222</sup> It is unclear to what extent MHSA funds could be used for mentally ill offenders. While MHSA programs may not provide services to state prisoners and parolees,<sup>223</sup> one of the specific goals articulated in the MHSA's "Vision Statement" is collaboration with "local resources such as . . . law enforcement and criminal justice systems,"<sup>224</sup> and reducing "negative effects of untreated mental illness including reductions in . . . incarceration . . ."<sup>225</sup> Mentally ill people with criminal justice involvement are a priority population for several counties; however, the Department of Mental Health requires that MHSA funds be used in jails and juvenile justice facilities "only for services that facilitate discharge."<sup>226</sup> In the summer of 2007, State Senator Darrell Steinberg introduced a bill that would fund programs that "identify and treat offenders'

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Slovenko, *The Transinstitutionalization of the Mentally Ill*, 29 OHIO N.U. L. REV. 641, 641 (2003).

220. Initiative Measure (Prop. 63, approved Nov. 2, 2004), Mental Health Services Act of 2004, available at [http://www.dmh.ca.gov/Prop\\_63/MHSA/docs/Mental\\_Health\\_Services\\_Act\\_Full\\_Text.pdf](http://www.dmh.ca.gov/Prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf).

221. JUDICIAL COUNCIL OF CAL., *supra* note 208, at 1.

222. See Kara Zivin Bambauer, *Proposition 63: Should Other States Follow California's Lead?*, 56 PSYCHIATRIC SERV. 642, 642 (June 2005).

223. *Into the Mind of an Inmate*, S.F. CHRON., May 25, 2007, at B12.

224. VISION STATEMENT AND GUIDING PRINCIPLES FOR DMH IMPLEMENTATION OF THE MHSA, 3 (2005), [http://www.dmh.cahwnet.gov/Prop\\_63/MHSA/docs/Vision\\_and\\_Guiding\\_Principles\\_2-16-05.pdf](http://www.dmh.cahwnet.gov/Prop_63/MHSA/docs/Vision_and_Guiding_Principles_2-16-05.pdf).

225. *Id.* at 4.

226. MENTAL HEALTH SERVICES ACT IMPLEMENTATION STUDY: PHASE II, 5-6 (Nov. 2007), [http://www.dmh.ca.gov/Prop\\_63/MHSA/docs/CSSImplementationPhase2ExecSum.pdf](http://www.dmh.ca.gov/Prop_63/MHSA/docs/CSSImplementationPhase2ExecSum.pdf).

mental-health problems from the time of their conviction through their parole period.”<sup>227</sup> The bill was vetoed in January of 2008.<sup>228</sup>

Increased resources alone will not increase rates of treatment. California must also reconsider its civil commitment laws, which currently make it difficult for local officials to force a person with mental illness to get treatment. The Lanterman-Petris-Short Act (LPS) enables the state to commit individuals adjudged to be either a danger to others or “gravely disabled”—unable to provide food, clothing, and shelter for themselves—as a result of mental illness.<sup>229</sup> Commitment, known as a conservatorship, lasts for a year. Conservatorships can be renewed but, if challenged by the patient, must be supported in court with updated diagnoses. The LPS provides important civil rights to the mentally ill, but limits treatment. First, the law enables individuals to refuse treatment even if they might be too mentally ill to exercise sound judgment (making “voluntary” refusals to accept treatment potentially more suspect).<sup>230</sup> Second, the law permits commitment only after the illness has reached a crisis point.<sup>231</sup> Intermediate treatment for those unable to consent is needed.

We do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs, and may no longer recognize that they even need care.<sup>232</sup>

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227. *Into the Mind of an Inmate*, *supra* note 223.

228. Bill information, [http://info.sen.ca.gov/cgi-bin/postquery?bill\\_number=sb\\_851&sess=CUR&house=B&site=sen](http://info.sen.ca.gov/cgi-bin/postquery?bill_number=sb_851&sess=CUR&house=B&site=sen) (last visited Mar. 5, 2008).

229. CAL. WELF. & INST. CODE §§ 5000–5129 (West 1998).

230. Advance directives about mental health care can preserve individual preferences about treatment even when an individual is too incapacitated to express them. See John Monahan et al., *Mandated Community Treatment for Mental Disorder*, HEALTH AFFAIRS 34 (Sept.–Oct. 2003).

231. CAL. TREATMENT ADVOCACY COALITION, FACT SHEET: TALKING POINTS—WHY LPS MUST BE REFORMED, <http://www.psychlaws.org/StateActivity/California/factsheet1.htm> (last visited Mar. 5, 2008).

232. LITTLE HOOVER, *supra* note 137, at iii.

Ironically, mentally ill people cannot be forced into civil confinement and given treatment, but, if their mental illness results in criminal behavior, they can lose both their liberty and their best chance for effective treatment.

Perhaps the most radical reform would be to treat mental illness as a public health problem, regardless of the criminal status of those involved. This approach would encompass graduated sanctions and harm reduction in parole, but would extend to other factors as well. For example, Medi-Cal and Medicaid provide medical care to indigent populations. If a Medi-Cal or Medicaid recipient goes to prison, he or she is unenrolled, treated in prison, and re-enrolled (if eligible) upon release. If the CDCR were to contract out healthcare provision to Medi-Cal or Medicaid, mentally ill prisoners would no longer face medication and therapeutic shortages because they got lost in the shuffle.

California must move away from certain entrenched ideas to implement an epidemiological approach. Treating mental illness is a sound investment in public safety and a sound use of the public fisc, not a luxury. Recent mental health initiatives, many of which exclude mentally ill offenders, indicate that there is a great need for leadership and education on this issue. The mentally ill do not stop being ill once they are incarcerated. People with mental illness who commit crimes as a result of their illness are not less deserving or less in need of treatment. Focusing on the treatment needs of mentally ill offenders does not mean they will be “let off” and released from prison. California’s MDO program, which covers violent mentally ill prisoners, already protects public safety through its well-established regime for treating and civilly committing violent mentally ill offenders.<sup>233</sup>

*B. Implement a Flexible, Fully-Funded, Coordinated Mental Health Program in Prisons that Uses Data and Management Oversight to Ensure Quality Care is Provided*

The CDCR must make several changes to improve mental health care for its prisoners. Medical and therapeutic care programs must be flexible enough to accommodate the diverse needs of prisoners. Funding must be secured to ensure that prison health care and programming is fully staffed. Corrections officers must coordinate their priorities with medical treatment. Finally, information technology and management systems must ensure that programs achieve positive outcomes.

First, treatment can be improved by decentralizing its provision. California concentrates mental health treatment in a few facilities, such as the California Medical Facility in Vacaville (42.3% of inmates are in twenty-four-hour psychiatric care and receive therapy or counseling and take psychotropic medications) and the California Institution for Women (46.1%

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233. See *supra* notes 149–55 and accompanying text.

of inmates in therapy/counseling, 30.7% on psychotropic medications).<sup>234</sup> Prisoners are less likely to fall through the cracks if they do not have to be transferred to another prison for treatment.<sup>235</sup> Local treatment would also facilitate screening prisoners already in custody for late-onset mental illness. Prison can trigger mental illness in some inmates who do not present symptoms at the time of intake, and protocols should be developed to ensure that late-onset mental illness is identified and treated. Local treatment facilities capable of handling mental illness might provide greater flexibility to prison administrators and less disruption to mentally ill inmates. However, added resources must accompany decentralization—local prisons cannot be told to shoulder more of the treatment load without the money necessary to staff and equip treatment centers.

Second, the state must provide more resources for mental health treatment and programming in prison. The mentally ill, once imprisoned, do not get the care that they need, but a collateral effect of resource scarcity is that there are fewer resources to address inmates with non-acute psychological needs. “[I]nmates who need treatment for lesser problems, such as anger management and borderline personality disorders, rarely get it. That contributes to the great stress within the prison, and it frustrates inmates’ opportunities for parole.”<sup>236</sup> One ingenious solution proposed to deal with staffing shortages is to require recipients of state medical education grants (or reduced rates on student loans) to agree to work in prison health care for a set period of time.<sup>237</sup> In addition to providing needed services, the community at large would benefit as young doctors returned from their prison residencies with firsthand knowledge of what is really happening inside California’s prisons.

Third, health care providers should enlist COs to be the first line of treatment for mentally ill prisoners. COs should receive more support and training for dealing with mentally ill prisoners, including training on mental health symptomology and pharmaceutical treatment. Currently, any disciplinary report for a prisoner receiving mental health treatment must be reviewed by a clinician to see whether the prisoner’s mental illness

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234. BECK BJS STUDY, *supra* note 3, at 7.

235. *See supra* notes 34–36 and accompanying text.

236. Sterngold, *supra* note 99, at A16.

237. NIETO, *supra* note 33, at 48.

contributed to the misbehavior.<sup>238</sup> But the state should go further. Jurisdictions outside California have experimented with different ways of imposing discipline on mentally ill prisoners. In Utah, inmates are not punished for behavior that is related to or is the result of a mental illness, and Alabama does not punish “symptoms of a serious mental illness.”<sup>239</sup> In Ohio, mental illness testimony does not tend to exonerate prisoners from discipline-related sanctions but often results in a suspended sentence.<sup>240</sup>

Finally, the state’s information technology and data collection need to be revamped to accurately diagnose and manage mental health treatment. More patient data need to be standardized and shared, both within the prison system and among social service providers. Data integration would avoid duplication of effort, which would save needed resources. Better data would also ensure that prisoners would get treatment when they need it. The CDCR’s inadequate data collection and analysis<sup>241</sup> has “plagued” its ability to engage in adequate long-range planning.<sup>242</sup>

Jails and prisons in particular must integrate their data, since many prisoners migrate between the two systems. The State should fund mental health screenings in county jails to standardize the information collected and to eliminate the need for duplicate tests at reception centers.<sup>243</sup> Standardizing information would also help establish and maintain effective release programs.<sup>244</sup>

Prescription information and drug supplies must accompany prisoners whenever they are transferred between jails and prisons, different parts of the prison system, and when they are released into parole. Medicated prisoners should take identical medication whenever transferred. Although a single diagnosis can be addressed by many drugs, side effects can be

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238. CAL. CODE REGS. tit. 15 § 3317 (2006).

239. Michael Krelstein, *The Role of Mental Health in the Inmate Disciplinary Process: A National Survey*, 30 J AM. ACAD. PSYCHIATRY L. 488, 494 (2002), available at <http://www.jaapl.org/cgi/reprint/30/4/488>.

240. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 63.

241. *Id.* at 6.

242. *Id.* at 6 n.4.

243. NIETO, *supra* note 33, at 47.

244. JOHN MONAHAN, VIOLENCE RISK ASSESSMENT, COMPREHENSIVE HANDBOOK OF PSYCHOLOGY 25–30 (Feb. 9, 2001) (unpublished, on file with author).



different. Changing medication may disorient mentally ill prisoners in an already disorienting environment, interfering with their ability to adjust to prison.

Ultimately, California needs to track mentally ill county inmates, state prisoners, and parolees across jurisdictions and integrate treatment. The State could insert mental health information into one of the existing criminal justice databases, such as the Parole Automated Tracking System or the California Law Enforcement Telecommunications System (which tracks criminals across jurisdictional lines).<sup>245</sup> Alternatively, the state could apply for funds from the National Criminal History Improvement Program to computerize criminal history records and include mental health fields in the resulting database.<sup>246</sup> Regardless, any attempt to reform the state's antediluvian correctional information technology must standardize databases and have a central administrator oversee the project, as recommended in 2004 by the Corrections Independent Review Panel.<sup>247</sup>

### *C. Tailor Programs to the Mentally Ill Population*

Mentally ill prisoners need more programs, and alternatives to standard policies, where appropriate, should be developed. The CDCR should consider the possibility of separate housing for the mentally ill, separate disciplinary procedures, and an expansion of tailored post-release programs. Furthermore, California should tailor programs to individual subpopulations of mentally ill prisoners, particularly female prisoners with mental illness.

Prison officials need to identify which programs for the general population are particularly effective for the mentally ill and enroll mentally ill prisoners in them. At the same time, officials should adapt existing non-penal mentally ill programming for use in correctional environments. These programs must address not only post-release needs (self-care, job skills, information about federal and state post-release programs) but deeper psychological needs as well. Some programs should specifically target prisoners with co-occurring drug and alcohol abuse, since their rate of

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245. NIETO, *supra* note 33, at 47.

246. PETERSILIA, WHEN PRISONERS COME HOME, *supra* note 141, at 108. Given that many states make criminal records publicly available online, however, there might be medical privacy issues under the Health Insurance Portability and Accountability Act of 1996. *Id.*

247. See REPORT OF THE CORRECTIONS INDEPENDENT REVIEW PANEL, *supra* note 98, at 121–22.

recidivism is much higher than that of either the mentally ill or the general prison populations. Other programs should target mentally ill prisoners with histories of emotional, physical, and sexual abuse, to address the legacy of abuse and help prisoners avoid becoming abusers themselves.

The CDCR needs to modify its approach to safety, discipline, and housing to reflect the reality of mentally ill prisoners. First, mentally ill prisoners are more likely to be victimized by other inmates and also more likely to violate prison rules. The result in both cases is often solitary confinement,<sup>248</sup> either as punishment or protective custody. Given the harsh, decompensating effects of solitary confinement, officials should develop alternative punishments or ensure that therapy and drug treatment continue throughout administrative segregation. Second, the mentally ill should be housed according to their particular diagnoses and treatment. Some inmates should not be housed with the general population, both for their safety and for the safety of those around them. Others might benefit from a regime in which somewhat less traditional disciplinary rules prevail, avoiding a cycle of violations and solitary confinement without sacrificing officer safety.

The CDCR must also develop and implement programs and staff training for female mentally ill prisoners. Female prisoners are particularly susceptible to depression as a result of separation from children and family. In fact, 10–15% of women entering reception centers suffer from depression.<sup>249</sup> This population is particularly susceptible to discipline problems: “female prisoners currently on psychotropic medications had annual infraction rates that were twice that of other women prisoners—and, indeed, had higher infraction rates on average than male prisoners who were also on medication.”<sup>250</sup>

#### *D. Transform the Culture of Failure*

The system needs a major overhaul. All parties with any involvement in the corrections system need to acknowledge openly that the prison system has failed for years to provide adequate treatment for mentally ill prisoners. Every few years, new reports document the lack of record keeping, the inadequacy of mental health care, and the needless duplication of effort and expense that goes into the wasteful system. However, nothing seems to change except the dates on the latest atrocious review of CDCR policies. Over ten years ago, *Coleman* described the prison mental health system in words that could apply with equal force today: “[d]efendants have been

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248. See *supra* notes 14–16 and accompanying text.

249. NIETO, *supra* note 33, at 22.

250. HUMAN RIGHTS WATCH, ILL-EQUIPPED, *supra* note 3, at 39.

confronted repeatedly with plain evidence of real suffering caused by systemic deficiencies of a constitutional magnitude. Their responses have frequently occurred only under the pressure of this and other litigation.”<sup>251</sup> Litigation has forced the state to address these problems, but reform via the courts is expensive and removes any discretion from corrections officials. The state should address these problems proactively. The CDCR could begin publishing a shame table of the worst facilities, in terms of untreated prisoners and abuses, or it could provide incentives for honesty in reporting mental health problems so that accurate information, the predicate to any solution, can finally be obtained. But throughout eleven years of court supervision, seventy-seven substantive court orders, and “thousands of hours” of court-supervised implementation,<sup>252</sup> the CDCR has failed to remedy its constitutionally deficient care. It is therefore with some frustration that this article is concluded, by noting that none of these recommendations are particularly novel. The problems have been diagnosed before. All that is lacking is the administrative skill and political will to implement them. As the system undergoes another stinging rebuke from the justice system and a period of receivership, one can hope that lessons will finally be learned. All the citizens of California, not merely those incarcerated with mentally illnesses, deserve no less.

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251. *Coleman v. Wilson*, 912 F. Supp. 1282, 1311 (E.D. Cal. 1995).

252. *Coleman v. Schwarzenegger (Coleman II)*, No. Civ S-90-0520 LKK JFM P, 2007 WL 2122636, at \*2–3 (E.D. Cal. July 23, 2007).