

Stanford Law School

Stanford Criminal Justice Center

***The Effect of Realignment on Mentally  
Ill Offenders***

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# Summary

With the recent Supreme Court decision in *Brown v. Plata*, “realignment” seems to be California’s new criminal justice buzzword. Underlying the Court’s decision in *Brown*, however, lay two important class action suits – *Coleman v. Brown* and *Plata v. Brown* – that served as the driving forces behind the Court’s decision. These cases alleged Eighth Amendment violations in California’s prison system based on deficiencies in mental health care and medical care, respectively. With the Court crediting the Constitutional violations and lack of adequate care alleged in *Coleman* and *Plata* to an oversized prison population, overcrowding emerged as the issue of the day. State legislators responded to the Court’s directive to rapidly decrease California’s prison population with AB 109, public safety realignment legislation geared toward ameliorating prison overcrowding.

Ironically, though they were the impetus behind this legislation, the mentally ill have largely been left out of the realignment conversation. Little mention – if any – has been made of how AB 109 improves or even addresses the treatment of the mentally ill. This paper will analyze AB 109 to determine how closely it rings true to the spirit behind the *Brown v. Plata* litigation – namely, providing mentally ill offenders with adequate medical and psychiatric care – and what impact the bill will have on the mentally ill. More specifically, this paper will assess whether AB 109 marks yet another in a long series of failed attempts by the state to appropriately address the treatment of mentally ill individuals in state custody.

One of the basic themes behind this paper is a recognition of the importance of mentally ill offenders in California, not only in terms of the litigation that sparked realignment, but also from a general corrections standpoint. Research shows that mentally ill offenders recidivate at a much higher rate than non-mentally ill offenders. Therefore, it is crucial from a public safety perspective to determine where realignment is going to place these individuals. Further, AB 109 is not the first alignment of state and local fiscal and administrative responsibility in California that implicates the treatment of the mentally ill. It is necessary to attempt to determine what effects realignment will have on California's mental health resources, which have been scarce for much of the state's history.

While not the focus of this paper, underlying much of the discussion will be the disturbing, yet generally accepted fact that prisons and jails in the United States largely operate as de facto mental hospitals. In California in particular, well-intentioned efforts to deinstitutionalize the mentally ill from state hospitals have had disastrous consequences, with the result being that many mentally ill individuals have ended up in the one place that accepts almost everyone: the criminal justice system. If there is one thing that most people seem to agree on, it is that many of the state's previous attempts to address this population have been ineffective. Mentally ill offenders are likely to struggle in the correctional system, whether at the state or local level. This paper explores, but does not intend to answer important questions such as: How do you hold mentally ill offenders accountable? Is this a population that we should even be seeking to imprison?

## **Scope of this Report**

This paper seeks to determine whether AB 109 is a step in the right direction in improving California's treatment of mentally ill offenders. In making this determination, I was guided by several broad research questions:

- Does AB 109 align to previous state efforts to provide effective treatment for mentally ill individuals in state custody?
- Does AB 109 align with the impetus behind the *Brown v. Plata* litigation?
- What are the unintended consequences, if any, of AB 109 on mentally ill offenders?
- Are county jails and communities equipped to handle an influx in the mentally ill population?
- Will decreasing overcrowding resolve the issues this legislation was intended to address?

## **A Note on Methodology**

As AB 109 was (seemingly) enacted to address the mentally ill offender population, I first turned to the text of AB 109 to see what the legislation actually says about the treatment of the mentally ill. I then turned to the three offender population groups that realignment impacts to determine how mentally ill individuals will be affected within each of these population groups. These groups include: newly sentenced individuals who will be realigned to county jail, individuals released from state prison into post-release community supervision, and individuals who will stay in prison under realignment.

## **Conclusions & Recommendations**

At outset, it should be noted that none of the recommendations listed below are particularly novel in concept. Most of these ideas have been proposed at some point or another and followed by some counties. In the realignment context, however, it is all the more important to actually adhere to and adopt these recommendations.

To begin, the mentally ill are a high risk, high needs group and must be treated as such. Realignment will cause a population shift in county jails and local supervision that will implicate the need for the effective management of mentally ill offenders. Many counties, however, are currently ill-equipped to do so due to their allocation of resources under their county plans. Counties must allocate funds and resources to both corrections and supervision that is focused on preventing the re-incarceration of the mentally ill. Many counties have done so already with their use of full service treatment programs run through departments of probation and mental health. Evidence-based practices will be crucial here in ensuring local jurisdictions expend their resources appropriately and divert mentally ill offenders from the criminal justice system when necessary. Along this same vein, counties are going to have to work smarter to develop partnerships across agencies to collaborate and share resources. It is essential that counties develop some semblance of a unified approach in collaborating across disciplines and agencies in order for the state's jails as a whole to be effective in the treatment of the mentally ill.

Realignment will increase the importance of screening and assessment for both mentally ill offenders who would have served their sentences in prison prior to

realignment, and for mentally ill offenders who will be released from state prisons to post-release community supervision. Screening is important for the former group to identify mental illness and subsequently tailor an appropriate delivery of services. For the latter group, screening will be important for pre-release planning, continuity of care, and linking ex-offenders to public mental health treatment providers in the community. While mentally ill individuals released to local supervision must be monitored, such monitoring should not be done in a way that results in a large number of technical violations. Though this has been the trend in the past, under realignment many jails will simply not have the capacity to continuously house mentally ill technical violators.

With the movement of low-level offenders from state prisons to county jails, California's prison population may become a more serious, hardened population in which mentally ill offenders are susceptible to victimization. The decrease in overcrowding must be supplemented at the state level by additional efforts to improve the treatment and supervision of mentally ill offenders in prison.

As a final note, realignment currently seems to be tracking past trends based on the state's decentralized system of care. Counties that have tended to focus more on rehabilitation with the mentally ill offender population have implemented many of these recommendations already, while counties that have tended to be less progressive in this area have not devoted a large proportion of their realignment funds to mental health services. In this way, realignment may repeat history in many counties that have focused more on incarceration than rehabilitation. Some benefits may accrue under realignment for mentally ill offenders in counties that have strategically allocated funds

to mental health services. Mentally ill offenders in counties that have not, however, may be the unintended losers under AB 109. Whether these counties will have the desire to even attempt to adhere to these recommendations remains to be seen. As a result, the impact of realignment on the mentally ill will vary widely by county.

# Chapter 1

## *Background*

California's mental health system has undergone a significant transformation since the early 1950's. Notably, these changes have been marked by a transition from a state-operated mental health system to a decentralized system of care, accompanied by major changes in the fiscal relationship between the state and local governments.<sup>1</sup>

Realignment will have a significant impact on California's local mental health resources, which have historically been scarce and underfunded. To place realignment's potential impact on mentally ill offenders in context, it is necessary to provide a brief overview of California's public mental health system leading up to the adoption of AB 109.

The mid-1950's marked the beginning of the deinstitutionalization of state-operated and funded mental health hospital systems. In 1957 Congress passed the National Mental Health Act and the Community Center Act, which provided money to states for the creation of community-based mental health facilities.<sup>2</sup> Concurrently, California lawmakers enacted the Short-Doyle Act, which required counties to assume larger roles in managing locally controlled mental health institutions.<sup>3</sup> To assist in the

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<sup>1</sup> Legislative Analyst's Office, Major Milestones: 43 Years of Care and Treatment of the Mentally Ill (2000), [http://www.lao.ca.gov/2000/030200\\_mental\\_illness/030200\\_mental\\_illness.html](http://www.lao.ca.gov/2000/030200_mental_illness/030200_mental_illness.html) [hereinafter 2000 LAO Report].

<sup>2</sup> 2000 LAO Report, supra note 1.

<sup>3</sup> 2000 LAO Report, supra note 1. Marcus Neito, Cal. Research Bureau, Mentally Ill Offenders in California's Criminal Justice System 3 (February 1999).

funding of this new system, the state initially covered 50% of the costs for those counties that chose to establish a mental health system.<sup>4</sup> State funding later increased to 75%.<sup>5</sup>

In the 1960's, California was pegged as leading the nation in community mental health development and civil rights for mentally ill individuals.<sup>6</sup> This was due in part to the 1968 enactment of the Lanterman-Petris-Short Act (LPS), which was intended to end the inappropriate, involuntary and indefinite commitment of mentally ill individuals.<sup>7</sup> LPS further facilitated the use and management of community-based care.<sup>8</sup> Under this legislation, state funding for community mental health programs increased to 90%.<sup>9</sup>

Following the success of the 1960's, California's mental health system lapsed into a period of funding instability and program confusion.<sup>10</sup> The period between 1969 through 1971 marked the first closure of state hospitals in California.<sup>11</sup> Though the legislature intended to have budget savings from the closures go to local programs, the "money [did not] follow the patient."<sup>12</sup> Thus, though state funding increased slightly for community-based services during this time, the state largely failed to distribute these increased funds to counties.<sup>13</sup>

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<sup>4</sup> Senate Committee on Budget and Fiscal Review, California's Mental Health System – Underfunded from the Start 3 (2000) [hereinafter Senate Committee Review].

<sup>5</sup> 2000 LAO Report, supra note 1.

<sup>6</sup> Cal. Mental Health Directors Assoc., History and Funding Sources of California's Public Mental Health System, 1 (2006) [hereinafter Cal. Mental Health Directors Assoc.].

<sup>7</sup> Meredith Lenell, The Lanterman-Petris-Short Act: A Review After Ten Years, 7 Golden Gate U. L. Rev. 733-34 (1977).

<sup>8</sup> Senate Committee Review, supra note 4.

<sup>9</sup> 2000 LAO Report, supra note 1.

<sup>10</sup> Cal. Mental Health Directors Assoc. supra note 6.

<sup>11</sup> 2000 LAO Report, supra note 1.

<sup>12</sup> 2000 LAO Report, supra note 1.

<sup>13</sup> Senate Committee Review, supra note 4.

Several pieces of legislation were enacted in the 1980's with the intent of addressing some of these shortcomings. The Bronzan-Majonnier Act contained significant provisions relating to identifying the shortage of services, especially those that resulted in the criminalization of the mentally disordered.<sup>14</sup> Additionally, the Wright, McCorquodale, Bronzan Act sparked significant reforms regarding services provided for adults with serious mental illnesses. Most significantly, the Act set forth a community-based, integrated system of care and established a coordinated service delivery model.<sup>15</sup>

Despite these reforms, many counties were still burdened by a lack of local financial resources.<sup>16</sup> This led to the 1991 enactment of the Bronzan-McCorquodale Act, more commonly referred to as realignment. California's 1991 realignment marked a major shift in authority from the state to counties, transferring financial responsibility for most of the state's mental health programs from state to local governments.<sup>17</sup> The legislation addressed the scarcity of local resources by providing counties with a dedicated source of revenue to pay for these changes.<sup>18</sup> The intent of California's 1991 realignment with regards to mental health resources was to: provide a more stable funding source for community-based services, shift program accountability to the local level, establish local advisory boards in each county to provide advice to local mental health directors, make services more client-centered and family focused, develop

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<sup>14</sup> 2000 LAO Report, *supra* note 1.

<sup>15</sup> Senate Committee Review, *supra* note 4.

<sup>16</sup> Neito, *supra* note 3 at 3.

<sup>17</sup> Cal. Mental Health Directors Assoc. *supra* note 6.

<sup>18</sup> *Id.*

performance measures and outcome data, and define the role of the state in providing services through the state hospital system.<sup>19</sup> Under realignment, the state continued to commit severely mentally ill individuals, with the majority of mentally ill individuals remaining the responsibility of the counties.<sup>20</sup> Levels of service for these individuals varied between counties.<sup>21</sup>

Up to this point, mentally ill offenders have been largely left out of the discussion. Their plight, however, was very much bound to the funding instability and resource scarcity described above. California's public mental health system has long been overburdened by the sheer number of people in need of care.<sup>22</sup> With the shift in responsibility from the state to local governments, many mentally ill individuals simply fell through the cracks and ended up in county or state correctional systems.<sup>23</sup> Some numbers are helpful here to illustrate the magnitude of this shift in responsibility: by 1994, 96% of people who would have received in-patient treatment in state mental hospitals in 1955 had to turn elsewhere.<sup>24</sup> As some observers have noted, "by squeezing the mentally ill out of civil treatment, they have shifted to a place where treatment both must be provided and cannot be refused – prison."<sup>25</sup>

With a huge shift in responsibility and the state and local governments already strapped for resources, it is not surprising that the federal district court in 1995 decided

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<sup>19</sup> Senate Committee Review, *supra* note 4.

<sup>20</sup> Neito, *supra* note 3, at 4.

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> W. David Ball, Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism 36 (January 2007).

<sup>25</sup> *Id.* at 37.

the case of *Coleman v. Wilson*, a class action lawsuit brought on behalf of all offenders in California's prison system who suffered from a serious illness.<sup>26</sup> The court in *Coleman* found CDCR's mental health services to be grossly and unconstitutionally deficient on a number of grounds: (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>27</sup> After the *Coleman* ruling, the court appointed a Special Master to oversee CDCR efforts to develop a system-wide receivership system.

Following *Coleman*, in 1998, the legislature signed into law the Mentally Ill Offender Crime Reduction (MIOCR) grant program, which appropriated competitive grants to counties that expanded or established a cost-effective continuum for mentally ill offenders.<sup>28</sup> These local mental health grants laid the groundwork for the passage of Proposition 63, dubbed the Mental Health Services Act (MHSA), which increased funding to support California's county mental health programs.<sup>29</sup> The MHSA aimed to expand access to public mental health services and restructure California's public mental health system into a more consumer-oriented model.<sup>30</sup> Two things are interesting to note here. To begin, most counties exclude violent offenders from their MIOCR programs.<sup>31</sup> Further, as of 2007, MHSA funds had not yet been used to fund

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<sup>26</sup> *Coleman v. Wilson*, 912 F. Supp. 1282 (E.D. Cal. 1995).

<sup>27</sup> *Coleman*, 912 F. Supp. at 1296-97. Ball, supra note 24, at 6.

<sup>28</sup> Neito, supra note 3, at 4.

<sup>29</sup> Mistique Felton, MPH, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, Proposition 63. The Mental Health Services Act: A Research Agenda 1 (2006). Cal. Mental Health Directors Assoc. supra note 6, at 6.

<sup>30</sup> *Id.*

<sup>31</sup> Ball, supra note 24, at 30.

programs relating to mentally ill prisoners.<sup>32</sup> Many counties even have prohibitions against using MHSA monies for criminal justice clients.<sup>33</sup>

California's decentralized public mental health system has set the stage for realignment. As mental health services vary widely by county, the treatment of mentally ill offenders across the state under realignment will also be expected to vary. This paper now turns to defining these populations of offenders.

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<sup>32</sup> Id. at 38.

<sup>33</sup> Cal. Corr. Standards Authority (CSA), Jails and the Mentally Ill: Issues and Analysis 4 (2009) [hereinafter CSA Jail Analysis].

## Chapter 2

### ***Defining the Mentally Ill Offender Population***

The focus of this paper hinges on a determination of the number and composition of mentally ill individuals in state and local custody. As such, it is necessary to define this population.

At outset, it is important to note that there is no uniformly accepted definition of “mentally ill offender.” This term is understood differently not only between counties, but often within counties, between jails in the same county, between custody and mental health personnel, not to mention between state and local corrections.<sup>34</sup> The basis for this ambiguity is perhaps the breadth of mental illness. Mental disorders include a broad range of impairments of thought, mood and behavior, including milder forms of illness, such as anxiety and depression, as well as more severe forms of illness, such as bipolar disorder, schizophrenia, and full-blown decompensation.<sup>35</sup> The mentally ill offender population thus consists of a broad spectrum of severity and acuteness of psychopathology and wide variation with respect to treatment needs.<sup>36</sup>

Additionally, mental illness is often not isolated. Many mentally ill offenders have co-occurring disorders: a combination of both mental illness and substance abuse

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<sup>34</sup> *Id.* at 5.

<sup>35</sup> Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness 30 (2003) [hereinafter Human Rights Watch, Ill-Equipped]. Spearlt, Mental Illness in Prison: Inmate Rehabilitation & Correctional Officers in Crisis, 14 Berkeley J. of Crim. Law 227, 281 (2009).

<sup>36</sup> Coleman Rebuttal Export Report of James Gilligan, M.D. [hereinafter Gilligan Rebuttal Export Report] 1, August 27, 2008.

disorders.<sup>37</sup> According to a 2006 nationwide study by the Bureau of Justice Statistics, about 74% of mentally ill state prisoners and 76% of mentally ill local jail inmates also met the criteria for substance dependence or abuse.<sup>38</sup> For the purposes of this paper, mental illness should be understood to include co-occurring disorders.

This paper relies on statistics from state prisons and local jails in determining the population of mentally ill offenders in custody. Admittedly, these statistics may not be wholly reflective of the actual prevalence of mental illness in corrections facilities, given the varying ways in which agencies tend to define mental illness. A comparison of data from the California Department of Corrections & Rehabilitation (CDCR) and the Bureau of Justice Statistics will be helpful in illustrating this point. According to a recent estimate by the CDCR, 23.1% of inmates in the CDCR system are mentally ill. The Bureau of Justice Statistics, however, found that 56% of state prisoners nationwide had a mental health problem.<sup>39</sup> While this discrepancy may be a result of comparing statewide data to a nationwide sample, it may also be a result of the slightly under-inclusive way in which the CDCR defines mental illness (individuals who are on a mental health treatment caseload) as compared to the Bureau of Justice Statistics (individuals who either had a recent history or current symptoms of a mental health problem). According to 2009 data, 33% of the statewide jail population is mentally ill (individuals who have open mental health case files) with 11% of the population receiving psychotropic medication.<sup>40</sup> Regardless of the definition, it is clear that

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<sup>37</sup> CSA Jail Analysis, *supra* note 33.

<sup>38</sup> Doris J. James & Lauren Glaze, Bureau of Justice Statistics, U.S. Dept. of Justice, Mental Health Problems of Prison and Jail Inmates 1 (2006) [hereinafter BJS Study].

<sup>39</sup> *Id.*

<sup>40</sup> Cal. Dep't of Corr. and Rehab., Corrections Standards Authority, 2007 Annual Jail Profile Survey Report, [http://www.cdcr.ca.gov/CSA/FSO/Surveys/Jail\\_Profile/Jail\\_Profile\\_Survey.html](http://www.cdcr.ca.gov/CSA/FSO/Surveys/Jail_Profile/Jail_Profile_Survey.html) (2007). CSA Jail Analysis, *supra*

mentally ill offenders constitute a significant proportion of the statewide corrections population.

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note 33, at 3.

## Chapter 3

### *Mentally Ill Offender Populations Affected by Realignment*

#### **Individuals realigned to county jails**

In terms of assessing realignment's impact on individuals who would have been sentenced to state prison but for realignment, the main question to ask is: are our jails ready to do what our prisons could not as far as the treatment of the mentally ill?

This answer tends to vary by county. Generally speaking, local correctional systems have not traditionally engaged in long-term strategic planning on how to best identify and serve the mentally ill offender at the local level.<sup>41</sup> County jails, unlike state prisons, are not under court order requirements to provide mental health services to mentally ill offenders. Many county jails have been characterized by insufficient treatment, services, and a lack of coordination among service providers.<sup>42</sup> While data is not currently available on how many mentally ill offenders will be realigned to county jails, it is safe to say that there will be severely and moderately mentally ill offenders realigned to local corrections systems. It is therefore not surprising that a key concern is that under realignment, many of these systems will be ill-equipped to meet the needs of mentally ill offenders.<sup>43</sup>

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<sup>41</sup> Neito, *supra* note 3, at 1.

<sup>42</sup> Neito, *supra* note 3, at 4.

<sup>43</sup> RAND Corporation, *What Are the Public Health Implications of Prisoner Reentry in California?* 6 (2011) [hereinafter RAND Corp Study] (summarizing research reported in Davis L.M., Williams M.V., DeRose K.P., Steinberg P, Nicosia N., Overton A., Miyashiro L., Turner S., Fain T., and Williams E III, *Understanding the Public Health Implications of Prisoner Reentry in California: State-of-the-State Report*, 2011, <http://www.rand.org/pubs/monographs/MG1165.html>).

Much of this shortage of mental health resources will be linked to funding. Even before the current financial crisis, there was no dedicated funding stream for mental health services in jails.<sup>44</sup> Funding sources were provided, when available, but they tended to be mostly short term and unpredictable.<sup>45</sup> Additionally, many counties are already strapped for resources. Overall, California county jails are crowded.<sup>46</sup> This does tend to vary by county, however, as some jails have extra space.<sup>47</sup>

While funding is provided under AB 109, the legislation gives counties almost complete discretion with how to spend the funds. AB 109 tasks the Community Corrections Partnership (CCP) of each county with recommending and implementing a local plan to the board of supervisors for implementation of realignment.<sup>48</sup> These county plans include recommendations of how to maximize the investment of criminal justice resources in evidence-based correctional sanctions and programs, such as day reporting centers, drug courts, as well as funding allocations for custody, supervision, and services.<sup>49</sup> Though almost all the county plans currently available at least refer to mental health services, few counties went into any depth of discussion as to what these services will actually entail.<sup>50</sup> It is thus apparent that counties will vary widely in the amount of funding and resources they will dedicate to mental health services.

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<sup>44</sup> CSA Jail Analysis, *supra* note 33, at 4.

<sup>45</sup> *Id.*

<sup>46</sup> Dean Misczynski, Public Policy Institute of California, Rethinking the State-Local Relationship: Corrections 10 (August 2011).

<sup>47</sup> *Id.*

<sup>48</sup> Penal Code § 1230.1, enacted by Section 458 of AB 109.

<sup>49</sup> *Id.*

<sup>50</sup> The counties coded as having the greatest depth of discussion on mental health services were: Humboldt, Kern, Madera, and Plumas, followed by Alameda, Butte, Contra Costa, El Dorado, Glenn, Marin, Mendocino, Merced, Monterey, Orange, Placer, Riverside, Sacramento, San Benito, San Francisco, San Luis Obispo, Santa Barbara, Solano, Sonoma, Stanislaus, Tulare, and Ventura. See “Comparison of County AB 109 Implementation Plans” for additional details.

The legislature, responding to initial budgetary concerns, suggested that counties use their Proposition 63 dollars to fund mental health programs, including those for mentally ill individuals in jail. While this might be possible in some counties, many counties have prohibitions against using MHSA funds for criminal justice clients.<sup>51</sup> Further, any available MHSA funds may be limited, as the legislature is considering redirecting some MHSA funds from counties to pay for what were formerly state-funding services.<sup>52</sup>

Some counties are concerned about their capacity to meet increased demand for mental health treatment, as a number of low-level offenders to be housed and monitored at the county level are expected to include individuals who will require treatment programs.<sup>53</sup> Officials in Yolo County have already expressed concerns that they do not have the funding necessary to handle such an influx of mentally ill offenders in their jails. Supervisor Don Saylor of Yolo County related that of the \$3.3 million initially allocated under the county plan, the amount designated for mental health services (\$88,000) was “not nearly enough.”<sup>54</sup> Another Yolo County supervisor lamented that instead of looking at the best uses for realignment funds, the budget process turned into a “funding security plan.”<sup>55</sup>

As these variations make clear, the impact of AB 109 on mentally ill offenders realigned to county jails will be contingent upon the amount of funding and attention

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<sup>51</sup> CSA Jail Analysis, *supra* note 33.

<sup>52</sup> *Id.*

<sup>53</sup> RAND Corp Study, *supra* note 43.

<sup>54</sup> David Greenwald, *Advocates Express Concern that AB 109 Plan Lacks Funding for Mental Health Services*, Yolo Judicial Watch, October 28, 2011, [http://davisvanguard.org/index.php?option=com\\_content&view=article&id=4791:advocates-express-concern-that-county-ab-109-plan-lacks-funding-for-mental-health-services&Itemid=100](http://davisvanguard.org/index.php?option=com_content&view=article&id=4791:advocates-express-concern-that-county-ab-109-plan-lacks-funding-for-mental-health-services&Itemid=100).

<sup>55</sup> *Id.*

counties invest in mental health resources. Dr. Nancy Pena, Director of Mental Health for Santa Clara County expresses that outcomes will vary between counties as a result of these decisions. Mentally ill offenders may tend to fare off better under realignment in counties that have had past practices of taking a progressive approach to mental health care. There is even potential in these counties that have more programming for mentally ill offenders to benefit from than what would have been available to them in a prison environment.

Dr. Pena relates that Santa Clara is one such county. Santa Clara County has devoted much funding and attention towards services. As a result, under realignment, resources will be made available to mentally ill offenders at the local level that were not available before realignment. The county's basic premise is that mentally ill offenders have needs in major life domain areas; the more the county is able to address these needs through well-delivered, effective services, the better this population will fare in life domain areas, and the less likely they are to re-offend. Of course, these outcomes will vary by county. In Los Angeles County jail, for example, which has been cited as the nation's largest mental hospital with in excess of 3,000 mentally ill inmates on any given night, will not have the capacity to operate under such an approach to services.<sup>56</sup>

Dr. Pena relates that there may be potential drawbacks for this offender population, as well. Mental health care in local jails has historically been geared towards screening and treatment in the short term. As the average length of stay increases under realignment, jails may find themselves largely operating as mental health treatment

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<sup>56</sup> Neito, *supra* note 3, at 8.

facilities. Jails are thus going to have to gear up to become an environment that has the capacity to treat mental disorders on a long-term basis. Another potential drawback is that in most jails, there is no segregated mental health programming for people who have serious mental illnesses, other than the acute psychiatric unit. Such segregated programming may be necessary for the more severely mentally ill, as we'll see later at the state prison level. While Santa Clara County does have a segregated unit, they are one of the only counties who do.

The housing argument cuts both ways, however, as Dr. Pena explains that mentally ill offenders may benefit from the less institutionalized culture of county jails as compared to state prison. County jails provide a greater breadth of access to visitors, which may allow many mentally ill offenders to maintain a connection to their families. On the other hand, Dr. Pena explains that many mentally ill offenders are an at-risk population and may not fare well in dynamic county jail populations. The intensity of movement in and out may make it harder for mentally ill individuals to develop relationships and have some semblance on healthy social interactions.

In every county, collaboration between the county's key players will be crucial in securing the effective treatment of mentally ill offenders who are realigned to county jails. Partnership between local corrections, departments of mental health, courts, probation officers, and criminal practitioners will be necessary in serving mentally ill offenders at the local level. Jails will require these partnerships to develop and provide the integrated the treatment that is necessary for this offender population, including delivery of services, facilitating transition and re-entry for those released from jail, and

reducing recidivism. Not all counties are similarly teed to form such relationships, however. While in some counties these partnerships are strong and productive, in others the relationships are tenuous and lacking.<sup>57</sup> Additionally, some departments of mental health consider jail mental health services ancillary to their core responsibilities.<sup>58</sup> Further, often times there is little cooperation between departments of mental health and departments of drugs and alcohol – a crucial partnership, as many mentally ill individuals have co-occurring substance abuse disorders. Interagency collaboration will be crucial for the effective treatment of mentally ill offenders in local custody and to ensure the best outcomes under realignment. “Coordination is key; otherwise California may end up with 58 separate, county-level implementation experiments.”<sup>59</sup>

Dr. Pena stresses the importance of having all the players involved in realignment maintain a dialogue about the appropriate course of action, particularly directors of local mental departments. As Dr. Pena explains, representatives from county mental health departments can play a role at the broadest level of this dialogue in terms of understanding behavior, personality traits, and the nature versus nurture aspects of the population that is coming into the system. Such representatives are uniquely able to advocate for the perspective of understanding the mental health aspects of people engaged in the criminal justice system, while also bringing understanding and subject matter expertise into the conversation.

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<sup>57</sup> CSA Jail Analysis, *supra* note 33, at 9.

<sup>58</sup> CSA Jail Analysis, *supra* note 33, at 8.

<sup>59</sup> RAND Corp Study, *supra* note 43.

Counties that have mental health courts may stand in a unique position to forge such relationships, because similar collaboration between local corrections and service providers takes place in these courts. Mental health courts are comprised of a unique collaboration between local law enforcement and mental health providers, with a distinct focus on providing mentally ill offenders with better access to treatment, consistent supervision, and support to reconnect with their families.<sup>60</sup> These courts have been shown to be effective in reducing recidivism and have been identified as a best practice based on the court's coordinated treatment approach, which provides consistent oversight and wraparound services for offenders with co-occurring disorders.<sup>61</sup>

While much of the conversation thus far has focused on the incarceration of non-violent, non-serious mentally ill offenders under realignment, diversion of some of these offenders from the criminal justice system must also be part of the conversation. Mental health courts are important because they can potentially divert mentally ill offenders from the criminal justice system, which will be crucial in freeing up the resources in county jails. Collaboration is necessary to help remove mentally ill people who do not belong in jail.<sup>62</sup> Mental health courts have historically provided such diversion from the penal system.

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<sup>60</sup> Administrative Office of the Courts, Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report, Attachment A [hereinafter Task Force for Criminal Justice] (2011), <http://www.cpda.org/2011-Task-Force-For-Criminal-Justice-Collaboration-on-Mental-Health-Issues-Releases-Final-Report-April-2011-Attachment-A.pdf>.

<sup>61</sup> CSA Jail Analysis, supra note 33, at 30-31.

<sup>62</sup> CSA Jail Analysis, supra note 33, at 9.

The Santa Clara County Mental Health Treatment Court, presided over by Judge Stephen V. Manley, is noted for being a particularly proactive court that identifies and treats mentally ill offenders and develops solutions to keep them out of the criminal justice system. Judge Manley stresses the importance of local criminal justice “partners” – probation, the sheriff, mental health and treatment providers, and criminal justice practitioners – in producing more effective outcomes for the mentally ill. He notes that the rehabilitative approach of mental health courts will be advantageous under realignment; many jails are already at capacity, so sentences cannot be “meaningless.” Further, research has shown that public safety outcomes can be improved significantly by the release or diversion of mentally ill offenders from short-term incarcerations.<sup>63</sup> From a rehabilitative perspective, counties with mental health courts will benefit from diverting mentally ill offenders from the criminal justice system, as local jails are not equipped to rehabilitate mentally ill offenders. Mental health courts provide essential judicial supervision and monitoring that has produced results. As Judge Manley affectionately reflects, “realignment we were doing 12 years ago: keeping people out of the jail and providing them treatment outside of jail.” Judge Manley further advocates that courts should be at the front end of this process. As he notes, “If we could get the courts to be a part of this [realignment], it could work.” The one downside to mental health courts, however, is their prevalence: as of 2008, California trial courts reported having approximately 40 mental health courts operating statewide.<sup>64</sup>

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<sup>63</sup> Coleman Expert Report of James Gilligan 6, M.D., August 25, 2008 [hereinafter Gilligan Expert Report].

<sup>64</sup> Task Force for Criminal Justice, *supra* note 60.

Additionally, mental health courts are unable to provide solutions to all the problems that may come along with realignment. In Judge Manley's mental health court, for example, Public Defender Malorie Street has expressed concern over how realignment's current 1170(h) rules will affect mentally ill offenders with strike offenses. Though these offenders may be brought before the mental health court, pursuant to realignment, they are absolutely prohibited from serving a local jail sentence, thus preventing and precluding any access to Judge Manley's mental health treatment court. Street further laments that this exclusion erodes the intent of realignment – that low-level mentally ill offenders do not serve time in prison – as the strike controls. She has handled four such cases to date.

Realignment will also increase the importance of screening and assessment at the local level. Mentally ill people enter county jails from a variety of directions: some are arrested for serious crimes, some are brought to jail by patrol officers who observe erratic behavior, some are brought by their families, etc.<sup>65</sup> With realignment promising an increase in the mentally ill offender population in local custody, particularly in large jails where resources are scarce, such as Los Angeles County jail, it will be increasingly important to immediately identify mentally ill offenders and provide the necessary treatment for them.<sup>66</sup>

Several takeaways from this section are clear. Local corrections will require stable funding and additional resources to effectively manage any increase in their mentally ill offender population. As funding is scarce and many counties have not

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<sup>65</sup> CSA Jail Analysis, *supra* note 33, at 17.

<sup>66</sup> CSA Jail Analysis, *supra* note 33, at 20.

allocated a significant portion of their realignment funds to mental health services, local agencies will have to collaborate to strategically expend the resources they do have. Interagency collaboration will also be crucial in the delivery of services and integrated treatment. As discussed, the mentally ill offender population is comprised of a variety of individuals with varying needs and degrees of illness. In this vein, corrections agencies must be aware of the fact that they are only a part of the puzzle. The mentally ill offender population is a highly specialized group; diversion from jail and access to aftercare and treatment services will be necessary in establishing an effective spectrum of care. Finally, jails must provide immediate, robust mental health screening to identify mentally ill offenders when they arrive and tailor their treatment as such.

### **Individuals released from state prison into post-release community supervision**

Another mentally ill offender population that will be affected under realignment is the population of offenders released from state prison. Under realignment, non-violent and non-serious offenders are released from state prison into post-release community supervision (PRCS), rather than state parole.<sup>67</sup> With the exception of individuals designated as “mentally disordered offenders,” discussed later, mental illness will not prevent an offender from being released into PRCS. It is therefore helpful to delineate exactly what types of mentally ill offenders will be coming home. While the vast majority of mentally ill offenders are no more dangerous as a group than

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<sup>67</sup> Penal Code § 3451, enacted by Section 479 of AB 109.

non-mentally ill offenders,<sup>68</sup> mentally ill offenders are more likely than non-mentally ill offenders to violate parole.<sup>69</sup>

The CDCR tracks populations of mentally ill offenders based on out-patient and in-patient treatment. The two most relevant groups within these populations for our purposes are individuals who do not require in-patient treatment: offenders in the Enhanced Outpatient Program (EOP) and the Clinical Correctional Case Management System (CCCMS).

CCCMS is the least intrusive level of mental health care.<sup>70</sup> Offenders with this mental health designation are typically housed within the general prison population and exhibit symptom control or are in partial remission.<sup>71</sup> These offenders tend to have Global Assessment of Functioning (GAF) scores of 50 and above.<sup>72</sup> As of August 2011, 31.8% of the female CDCR population and 18.2% of the male CDCR population were designated as CCCMS recipients.<sup>73</sup>

EOP individuals, on the other hand, require a more intensive level of care; they are generally housed apart from the general prison population.<sup>74</sup> EOPs are intended to

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<sup>68</sup> Gilligan Expert Report, supra note 63, at 18.

<sup>69</sup> Ball, supra note 24, at 3.

<sup>70</sup> Neito, supra note 3, at 15.

<sup>71</sup> Cal. Corr. Health Care Services, Mental Health Services Delivery System Program Guide, 2009. [hereinafter Mental Health Program Guide]

<sup>72</sup> GAF scores are clinical assessments of overall psychological, social and occupational functioning based on a 100-point scale. Higher scores reflect better overall functioning. A GAF score of 50 is indicative of serious psychological symptoms or serious impairment in social or occupational functioning. A GAF score of 40 is indicative of major impairment in areas just as judgment, thinking, mood, social or work relations. See Gilligan 10.

<sup>73</sup> See CDCR Division of Corr. Health Care Services, Mental Health Population and Percentages, [www.cdcr.ca.gov/.../DCHCS-WeeklyMentalHealthProgramData.doc](http://www.cdcr.ca.gov/.../DCHCS-WeeklyMentalHealthProgramData.doc). [hereinafter CDCR Mental Health Population and Percentages]

<sup>74</sup> Mental Health Program Guide, supra note 71.

provide extensive mental health resources for the most needy sub-acute cases: those needing intensive interventions, but not requiring hospitalization.<sup>75</sup> Offenders in EOPs usually have acute onset or significant decompensation.<sup>76</sup> They tend to maintain dysfunctional or disruptive social interaction or impairment in the activities of daily living.<sup>77</sup> Offenders requiring this level of care tend to have a GAF of less than 50. As of August 2011, 1.7% of the female CDCR population and 2.2% of the male CDCR population were designated as EOP recipients.<sup>78</sup>

One group of mentally ill offenders who are ineligible for post-release community supervision is the population of offenders who are designated as “mentally disordered offenders” (MDO’s).<sup>79</sup> These individuals will remain on state parole. MDO’s are individuals with the following characteristics: (1) a severe mental disorder that is not in remission; (2) the disorder was either one of the causes or an aggravating factor in a crime involving force or violence; and (3) poses a substantial danger of physical harm to others.<sup>80</sup>

As data on the number of mentally ill offenders who will be released from state prison into local supervision is not currently available, it is possible to roughly estimate the likely size of this population using past data on parole populations. As previously noted, mentally ill offenders recidivate at a higher rate than do non-mentally ill offenders, so it is beneficial to estimate the number of individuals under local

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<sup>75</sup> Human Rights Watch, Ill-Equipped, supra note 35, at 131.

<sup>76</sup> Mental Health Program Guide, supra note 71.

<sup>77</sup> *Id.*

<sup>78</sup> CDCR Mental Health Population and Percentages, supra note 73.

<sup>79</sup> Cal. Dept. of Corrections and Rehabilitation, Realignment Fact Sheet (2011), [http://www.cdcr.ca.gov/About\\_CDCR/docs/Realignment-Fact-Sheet.pdf](http://www.cdcr.ca.gov/About_CDCR/docs/Realignment-Fact-Sheet.pdf).

<sup>80</sup> *Id.*

supervision who will have mental health needs. Specifically, the recidivism rates for inmates in the EOP and CCCMS mental health programs are higher (77.6% and 74.3%, respectively) than those of inmates who do not have a mental health code designation.<sup>81</sup> In other words, EOP and CCCMS individuals have a recidivism rate of 8-11% higher than other offender populations.<sup>82</sup> According to 2006 data, close to 20% of state parolees each year have a documented history of psychiatric problems.<sup>83</sup> However, more recent data suggest this population may be slightly larger.<sup>84</sup>

Just as with mentally ill individuals who will be realigned to local jails, screening and identifying mental illness will be crucial in ensuring the effective supervision of mentally ill offenders who are released into local supervision. As a preliminary matter, the CDCR has been relatively proactive in easing along the transition from state parole to local supervision. The CDCR's Council on Mentally Ill Offenders (COMIO) has made available a realignment recommendations letter which details policy suggestions for providing cost-effective services to mentally ill offenders released to PRCS. Additionally, the CDCR will provide county probation departments with pre-release offender information packets containing relevant mental health information approximately 120 days prior to an offender's scheduled release.<sup>85</sup> This situation has two drawbacks, however. To begin, each county's department of mental health must opt in to receive this information. Further, relevant mental health information will only be

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<sup>81</sup> Cal. Dept. of Corrections and Rehabilitation, Council on Mentally Ill Offenders, AB 109 Recommendations Letter (2011), [www.cdcr.ca.gov/comio/uploadfile/pdfs/AB109\\_Letter.pdf](http://www.cdcr.ca.gov/comio/uploadfile/pdfs/AB109_Letter.pdf). [hereinafter AB 109 Recommendations Letter]

<sup>82</sup> *Id.*

<sup>83</sup> Gilligan Expert Report, *supra* note 63, at 11.

<sup>84</sup> AB 826 details that roughly 300 EOP and 1,600 CCCMS participants paroled each month prior to realignment. See [http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab\\_0801-0850/ab\\_826\\_cfa\\_20110815\\_140437\\_sen\\_comm.html](http://www.leginfo.ca.gov/pub/11-12/bill/asm/ab_0801-0850/ab_826_cfa_20110815_140437_sen_comm.html).

<sup>85</sup> Cal. Dept. of Corrections and Rehabilitation, Post Release Community Supervision Release Planning For Mental Health, [www.cdcr.ca.gov/realignment/docs/PRCS-mental-health-info.pdf](http://www.cdcr.ca.gov/realignment/docs/PRCS-mental-health-info.pdf) (September 29, 2011) [hereinafter PRCS Release].

provided for offenders at EOP levels or higher not individuals in CCCMS programs, unless the individual is subject to a Keyhea order, or forced medication.<sup>86</sup> Offenders receiving CCCMS level of care will only receive an information packet from their primary clinician or mental health pre-release staff identifying mental health resources that they can seek in their community.<sup>87</sup>

It is markedly clear that though the CDCR has put forth what appears to be a sincere effort to assure that counties receive mental health information for offenders being released to PRCS, the state has not provided a large safety net for these individuals. While offenders with EOP distinctions of care may have required more treatment in prison, CCCMS offenders will also require special care and supervision on PRCS. Mentally ill offenders in general tend to encounter a variety of factors that make it difficult to assimilate back into society. For instance, many parolees with mental illness live in poverty, are unemployed, and have few social supports.<sup>88</sup> The need for services for mentally ill offenders on PRCS will likely be huge.<sup>89</sup> Both EOP offenders and CCCMS offenders alike experience many barriers to successfully transitioning to the community.<sup>90</sup> The compounding of issues in this population makes their re-entry into the community more difficult. While the CDCR has provided for some linking of services for a portion of the mentally ill offender population who will be returning to local custody, they provide no services for the vast majority of mentally ill offenders – CCMS designated individuals – who will be returning home.

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<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> Task Force for Criminal Justice, *supra* note 60, at 35.

<sup>89</sup> RAND Corp Study, *supra* note 43, at 2.

<sup>90</sup> Task Force for Criminal Justice, *supra* note 60, at 40.

Additionally, under the current system, the CDCR provides no notification to counties of the mental histories of offenders who were not at EOP designations or higher while incarcerated. This truly marks an incomplete understanding on behalf of the CDCR of the treatment needs of this offender population. Though an offender's mental health may have been in remission or under control before he was released from prison, re-entry into the local community may incite a variety of stresses that could exacerbate his mental condition. It is thus necessary for county departments of probation to know the mental health treatment histories of the individuals being released on PRCS, to the fullest extent possible. Screening and assessment is necessary to determine whether mental health care is needed and to link the offender with the appropriate treatment. Likewise, an ex-offender's mental health history is important in ensuring continuity of medication. Both the mentally ill individual and the public would benefit from this knowledge.

While full details regarding the mental health composition of the PRCS population is not yet available, anecdotally, the experience of many local agencies has been that the individuals released on PRCS have had more severe mental health issues than was initially anticipated. In some cases, released mentally ill individuals were not flagged as needing mental health.<sup>91</sup> Los Angeles County, in particular, has reported incidents of newly released state prisoners arriving to local probation agencies with incomplete medical records and more serious mental illnesses than expected.<sup>92</sup> As

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<sup>91</sup> Greenwald, *supra* note 34.

<sup>92</sup> Anna Gorman, *State convicts arrive in L.A. County with costly mentally illnesses*, Los Angeles Time, January 8, 2012, <http://www.latimes.com/la-me-prisoners-mentalhealth 20120109,0,1313041.story ?track=latiphoneapp>.

county officials have estimated that about 30% of individuals released to PCRS will need mental health treatment of some kind, this presents a variety of concerns.<sup>93</sup>

Additionally, many local probation departments have not historically been the most receptive in dealing with the mentally ill offender population. Judge Manley remarks that this tends to be different in counties with mental health courts, which have changed the way probation officers approach supervision and rehabilitation. On the whole, however, probation officers often find ex-offenders with mental illness to be difficult to supervise, perhaps due to the population's higher treatment and service needs.<sup>94</sup> Studies have shown that ex-offenders with mental illness have a 70% higher risk of committing technical violations and are twice as likely as non-mentally ill offenders to have their parole suspended.<sup>95</sup>

This data reveals that many probation departments simply approach supervision of this ex-offender population in the wrong way. While it will be important to monitor mentally ill offenders released into PCRS, probation must approach supervision from a rehabilitative perspective. The mental illness of many parolees directly contributes to their violations, often for reasons unrelated to the commission of new crimes.<sup>96</sup> As ex-offenders who violate the terms of their PCRS will be sent to local custody instead of prison under realignment, probation must take a progressive approach to monitoring this group, only sending back into local custody those who truly need to be there from a public safety perspective.

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<sup>93</sup> *Id.*

<sup>94</sup> Task Force for Criminal Justice, *supra* note 60, at 35.

<sup>95</sup> *Id.*

<sup>96</sup> Ball, *supra* note 24, at 24.

Probation officers will also be integral in ensuring that offenders are linked with the appropriate public programs and community resources they need to successfully transition back into the community. So far this discussion has assumed that all mentally ill offenders released into PRCS will be willing to receive mental health treatment from local agencies, but experience has shown that many offenders are unwilling to receive treatment or even unaware of their need. In Los Angeles, for example, about 30% of the mentally ill offenders released refused to either meet with clinicians or be referred for treatment.<sup>97</sup> Further, data shows that accessibility to mental resources does tend to vary by county.<sup>98</sup> Probation will serve an important role in such resource-strapped counties by linking mentally ill ex-offenders with the treatment and care they need.

As discussed, pre-release planning is essential for this offender population. Both the CDCR and counties must communicate and coordinate efforts to identify mentally ill individuals as soon as possible before their release into PRCS. Recent stories have shown that one of the biggest challenges with this population will be accessing necessary records and getting individuals enrolled into public mental health programs in a timely manner. Counties will also need to take steps to change the thinking of probation officers when supervising this offender group. This will probably require the development of a closer partnership between probation and local departments of mental health. Probation officers will need to work closely with mentally ill offenders to aid in their rehabilitation, rather than simply technically violating them.

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<sup>97</sup> Gorman, *supra* note 92, at 24.

<sup>98</sup> In terms of access to mental health care resources, this study showed that a larger share of parolees in Alameda and Los Angeles counties returned to areas with lower levels of accessibility to mental health resources than parolees in Kern or San Diego counties. RAND Corp Study, *supra* note 43, at 5.

## **Individuals staying in state prisons**

Our conversation now comes full circle: how, if at all, will decreasing the state prison population assist mentally ill offenders in securing more appropriate treatment? Admittedly, much more time is needed to truly answer this question, but some initial thoughts can be given.

As mentioned earlier, the federal district court in *Coleman* found the mental health care in state prisons unconstitutional on a number of grounds, mainly relating to staffing, screening, and other administrative processes it deemed “extremely deficient.” While decreasing overcrowding may certainly improve the ratio of mental health care staff to mentally ill offenders, there are a number of other reforms that must be made to truly improve the treatment of mentally ill individuals in state prisons. To begin, realignment does not address the capacity for services that are offered for the mentally ill in prison. Many of the Constitutional violations discussed in *Coleman* and more recently, *Brown v. Plata*, are byproducts of understaffing and limited supply. There is thus a need to supplement whatever decrease in overcrowding realignment accomplishes with changes to the current system of mental health intake and treatment. Such changes include reforming poor prison policy and antiquated record keeping,<sup>99</sup> sparse training policies,<sup>100</sup> and addressing the prison mental health system’s “severe, chronic and well-documented” staffing shortages.<sup>101</sup>

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<sup>99</sup> Spearlt, *supra* note 35, at 286.

<sup>100</sup> Spearlt, *supra* note 35, at 289.

<sup>101</sup> Gilligan Rebuttal Expert Report, *supra* note 36, at 11.

With the shifting of low-level offenders to county jails, AB 109 may have the unintended effect of creating an environment in state prisons where mentally ill individuals are more likely to be victimized. Prison conditions are generally taxing on the mental health of all offenders, regardless of mental health history. When an offender is mentally ill, however, it compounds problems of overcrowding, violence, lack of privacy and isolation.<sup>102</sup> Mentally ill offenders, as a group, are more vulnerable to assault, sexual abuse, exploitation and extortion in prison.<sup>103</sup> According to a 2006 study, state prisoners who had a mental health problem were twice as likely as state prisoners without to have been injured in a fight since admission (20% compared to 10%).<sup>104</sup> Under realignment, mentally ill offenders in state custody might find themselves facing a more hardened prison population where they are more likely to encounter these problems.

It will thus be important for prison guards to identify mentally ill individuals and monitor their well-being. This is currently not the case in many prisons. Prisoners with mental illness are more likely to face discipline than inmates in general population.<sup>105</sup> Additionally, mentally ill prisoners are more likely to end up in administrative segregation, which tends to exacerbate or even precipitate mental illness.<sup>106</sup> Correctional officers' roles must be expanded in the rehabilitation and treatment of mentally ill inmates.<sup>107</sup> Such officers often lack the training to recognize the difference

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<sup>102</sup> Jamie Fellner, A Corrections Quandary: Mental Illness and Prison Rules.

<sup>103</sup> Human Rights Watch, Ill-Equipped, supra note 35, at 56-58.

<sup>104</sup> BJS Study, supra note 38.

<sup>105</sup> Ball, supra note 24, at 4.

<sup>106</sup> Ball, supra note 24, at 5.

<sup>107</sup> Spearlt, supra note 35, at 293.

between genuine mental illness and an inmate who is simply breaking the rules.<sup>108</sup> It will be necessary for these officers to closely monitor the population of mentally ill offenders to respond to any needs they may have, especially in light of what is sure to be a changing prison population.

### **Next Steps**

As has been said throughout much of this report, many of these predictions remain to be seen. It is thus important for counties to monitor the populations of offenders under local supervision to determine exactly who is coming out and what forms of treatment they need. At the state level, it is important for correctional agencies to begin to think of ways in which they can supplement a decrease in overcrowding with improved services for the mentally ill.

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<sup>108</sup> Spearlt, supra note 35, at 281-82.