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Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism

Tens of thousands of people with mental illness are currently serving terms in California state prisons.[1] These individuals do not get the care they need, serve longer terms than the average inmate, and are released without adequate support and preparation. The result is that they are more likely to violate parole and return to prison. The poor treatment of mentally ill people in California burdens the judicial system, drains the state's budget, and causes needless suffering. Reform of the California correction system's mental health treatment and programming is both urgent and necessary.

California prisons and jails currently treat more people with mental illness than hospitals and residential treatment centers. Ten-and-a-half percent of California state prisoners—approximately 17,000—are treated with psychotropic medications, while 12.5 percent receive therapy from a trained professional on a regular basis.[2] Only 4,778 people with mental illness were treated in Medi-Cal funded residential programs in Fiscal

[1] For the purposes of this paper, I do not discuss specific programs and policy recommendations for sex offenders and substance abusers who do not also have an underlying mental illness, although certain statistics do (when noted) include these people. California prisons do not offer any treatment programs for sex offenders; many prisons offer inmate-led group counseling for drug abusers. Steven Fama et al., Prison Law Office, California State Prisoners Handbook 262 (3d ed. 2001).

[2] Allen J. Beck & Laura M. Maruschak, Bureau of Justice Statistics, U.S. Department of Justice, Mental Health Treatment in State Prisons, 2000 6 (2001) (hereinafter "Beck Study"). Note that these figures are for enrollment in programs, not overall demand. Given the staffing problems in California prisons, discussed infra at 13-15, 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 "Ill-Equipped").

Year 2002-03,[3] while a staggering 197,184 inmates received outpatient mental health services in California jails.[4] In 2005, a California state report concluded that "jails have become the primary source of treatment for the mentally ill."[5] Nationally, the U.S. Bureau of Justice Statistics (BJS) estimates that 283,000 of the 2 million incarcerated people in the U.S. (approximately 16 percent) suffer from serious mental illnesses such as schizophrenia, major depression and bipolar disorder.[6] The rate of mental illness for prisoners is double to quadruple the rate for the U.S. population at large.[7] Jail and probation costs for these individuals in California alone exceed $300 million a year.[8]

People with mental illness are more likely to face discipline problems and victimization from fellow prisoners than inmates in the general population. Inmates with

[3] California Department of Mental Health, Medi-Cal Specialty Mental Health Services Reports, Medi-Cal Trend Report for FY 1998-99 through FY 2002-03, available at http://www.dmh.ca.gov/SADA/SDA-Medi-Cal.asp. These are unduplicated numbers—that is, they count individuals receiving treatment, not program enrollment.

[4] California Department of Mental Health, Involuntary Detention Reports, Involuntary Detentions in California Fiscal Year 2002-03 (2003), available at 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.

[5] California Board of Corrections and Rehabilitation, Mentally Ill Offenders Crime Reduction Grant Program: Overview of Statewide Evaluation Findings (March 2005), available at http://www.bdcorr.ca.gov/cppd/miocrg/reports/miocrg_report_presentation.doc (hereinafter "2005 MIORCG Report").

[6] Paula M. Ditton, Bureau of Justice Statistics, U.S. Department of Justice, Mental Health and Treatment of Inmates and Probationers 2 (1999) (hereinafter "Ditton 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 percent of female inmates are mentally ill. 547,800 people with mental illness are estimated to be on probation. Note that these figures exclude mentally ill prisoners in jail; while jail populations are important, see supra note 5, given the number of prisoners who are on trial and eventually transfer to state prison, the focus of this paper is on state corrections.

[7] See President's New Freedom Commission on Mental Health, Final Report (2003), available at http://mentalhealthcommission.gov/reports/Finalreport/FullReport.htm (finding that five to seven percent of adults have a serious mental illness); see also William Kanapaux, Guilty of Mental Illness, Psychiatric Times, Jan. 2004, at 1, available at http://www.psychiatrictimes.com/p040101a.html (finding that U.S. prisoners have rates of mental illness that are up to four times greater than rates for the general population).

[8] California Board of Corrections and Rehabilitation, Mentally Ill Offenders Crime Reduction Grant: Annual Report to the Legislature 2 (June 2004), available at http://www.bdcorr.ca.gov/cppd/miocrg/2004_annual_report/miocrg_2004_annual_report.doc (hereinafter "2004 MIOCRG Report").

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."[9] 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 population.[10] At the same time, the mentally ill are more vulnerable to assault, sexual assault, exploitation, and extortion from other inmates:[11] 36% reported being involved in a fight since admission, for example, compared to 25% of other inmates.[12]

Both disciplinary problems and victimization can lead to administrative segregation—the former for punitive reasons, the latter for protective reasons. Administrative segregation, in turn, tends to exacerbate (or, in some cases, precipitate) mental illness. [13] Mentally ill prisoners can thus find themselves in a vicious circle: mental illness leads to discipline/victimization problems, which leads to solitary confinement, which leads to decompensation,[14] which worsens mental illness, which results in further discipline/victimization and further segregation. Mentally ill prisoners have longer to suffer these harms since they serve, on average, 15 months longer for the same crimes than the non-mentally ill.[15] Their illness often prevents them from engaging

[9] Ill-Equipped at 59, citing aggression, disruptive behavior, and a refusal to follow orders due to an inability to conform one's conduct.
[10] Ditton Study at 9.
[11] Ill-Equipped at 56-58. Contributing factors include slower reaction times as a side-effect of medication and social isolation from the stigma of mental illness.
[12] Ditton Study at 9. A New York Correctional Association Study found that 54 percent of prisoners in intermediate care mental health units reported victimization, "including having property stolen and physical and/or sexual assaults." Ill-Equipped at 57.
[13] Madrid v. Gomez, 889 F. Supp. 1146, 1216 (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."
[14] Decompensation is the exacerbation of mental illness due to stress and/or failure of psychological defense mechanisms.
[15] Ditton Study at 8.

in prison programming that results in the acquisition of "good time" credits, meaning that they serve a greater percentage of their sentences.[16]

California prisons fail to address the reality of its mentally ill population. Prisons fail to adequately screen inmates for mental illness during intake, fail to offer special programming or housing, fail to provide basic treatment for many prisoners, and fail to address special needs upon release, as described infra at 8 et seq. The result is that mentally ill prisoners get sicker, stay longer, suffer more—and wind up back in prison soon after their release.

Mental health care has long been abysmal in California prisons. In 1995, a federal court in Coleman v. Wilson held the treatment of the mentally ill in the California corrections system so inadequate that it violated the 8th Amendment's prohibition on cruel and unusual punishment.[17]) The Coleman court held that the following deficiencies violated the Eighth Amendment of the U.S. Constitution: the lack of any screening mechanism for mental illness; staff shortages for mental health; the lack of quality-assurance mechanisms for evaluating mental health staff; delays and denials of medical attention; inappropriate use of punitive measures; and an "extremely deficient" records system.[18] Ten years later, the same problems continue to plague mental health administration in prison, as discussed infra at 12-13.

Problems with mental health care are symptomatic of problems in the prison health care system at large. Judge Thelton Henderson of the Northern District of

[16] Ill-Equipped at 126.
[17] Coleman v. Wilson, 912 F. Supp. 1282 (E.D. Cal. 1995). Coleman dealt with the mental health system for all prisons except Pelican Bay; a companion case, Madrid v. Gomez, 889 F. Supp 1146 (1995), was also successful in establishing the unconstitutionality of the level of care at the Pelican Bay supermax prison. See infra at 13.
[18] Coleman at 1296-97.

California placed the prison health care system in receivership in October 2005:[19] his judicial opinion described the system as "broken beyond repair" and stated that the California Department of Corrections and Rehabilitation (CDCR) was "incapable of successfully implementing systemic change".[20]

How, then, can California more effectively treat mentally ill prisoners and, at the same time, prepare for their release in a way that will minimize recidivism? I will examine three critical stages in the penal system's relationship with mentally ill prisoners: intake, living in prison, and release.

INTAKE

During intake, inmates are screened and evaluated at intake centers before being transported to the prisons where they will serve their sentences. Officials take note of any health problems, including mental health, and assess other special needs in order to tailor housing and programming to each inmate. Prisoners transferred from county jail should, in theory, be accompanied by their screening, health, and disciplinary records.

Mentally ill prisoners should be identified during intake and provided with any necessary short-term care, such as medicine and therapy. (For long-term care, see infra at 11.) Early identification of mental illness enables early treatment, which is more effective. Early treatment also comports with the 8th Amendment's prohibition against cruel and unusual punishment, which requires the prison system to provide mental health care "before inmates suffer unnecessary and wanton infliction of pain."[21]

[19] Plata v. Schwarzenegger, 2005 WL 2932253 at 1(N.D. Cal. Oct. 3, 2005).
[20] Plata at 5.
[21] Coleman at 1305.

Prisoners with existing diagnoses also benefit from intake screening: prescriptions and/or medications themselves often fail to accompany prisoners at intake.[22] Information often fails to accompany prisoners as well. Pursuant to California law, county jails are required to evaluate the mental health of their prison population, but very few records get transferred to the state prison system.[23] Because so few records are transferred, state prison reception centers have to administer their own tests. One study estimated that 30 percent of all medical tests are needless duplications of county screens, costing up to 5 million dollars per annum.[24] As of this writing, county jails and the state prison system have yet to work 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.[25]

California's screening process, developed in response to the Coleman lawsuit, is inadequate, notwithstanding court orders to improve it. According to the policy, mentally ill prisoners should get a "red flag" during an intake interview; no more than 72 hours later they should receive a more detailed psychiatric screening; and within 18 days they should receive a psychiatric evaluation.[26] The Plata court, however, found that "the reception center intake process … fails to adequately identify and treat the health care problems of new prisoners."[27] An adequate screen should take at least fifteen minutes to administer; "[h]owever, prisoners' exams in CDCR reception centers typically last no

[22] Marcus Nieto, California Research Bureau, Health Care in California State Prisons 17 (June 1998).
[23] Nieto at 1.
[24] Nieto at 16. Note that these figures are for all tests, not just those for mental health.
[25] Coleman at 1314.
[26] Nieto at 19.
[27] Plata at 12. 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.

more than seven minutes."[28] Inmates are often screened in groups without regard to confidentiality; the examinations are therefore far less likely to be accurate.[29] Screens need to incorporate objective factors as well as self-reporting, since inmates with acute mental illness might be unable to communicate their symptoms and/or diagnoses.[30]

Screens must also account for co-occurring disorders—that is, 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.[31] Screening for drug abuse alongside mental illness is crucial in the penal context, however: chemical reactions in the brain cause seventy percent of California prisoners' major mental disorders, the primary cause of which is use of mind-altering drugs.[32] Nationwide, six in ten mentally ill state prison inmates report being under the influence of alcohol or drugs at the time of their offense.[33] Rates of violent crime for the mentally ill are no greater than that of the general prison population, but incidence of violent crime for mentally ill prisoners who

[28] Id. Again, this refers to all health screens, not just mental health. While no intake mental health screen was examined for this paper, a Suicide Prevention Assessment Form provides some insight into the types of questions asked: health problems, suicidal ideation, and history of hospitalization. California Department of Corrections and Rehabilitation, Corrections Standards Authority, Suicide Prevention Assessment Form, available at http://www.bdcorr.ca.gov/stc/stc.htm (last visited Dec. 20, 2005). All answers are self-reported. Additionally, 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. Id.
[29] Plata at 13.
[30] Coleman at 1305.
[31] National Commission on Correctional Health Care, Position Statements: Mental Health Services in Correctional Settings, available at http://www.ncchc.org/resources/statements/mentalhealth.html (last visited Sept. 13, 2005).
[32] Nieto at 20.
[33] Ditton Study at 7.

also abuse drugs and alcohol are much greater.[34] Yet there are few drug treatment programs in county jails, and no drug treatment programs at CDCR reception centers.[35]

California's inadequate screens are also administered at a rate below the national average. 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.[36] 67.7 percent of such facilities nationwide (1055 of 1558 facilities) conducted mental health screening at intake, while 63.5 percent (990 facilities) conducted psychiatric assessments.[37] Of the 86 comparable facilities in California, 58.1 percent screened inmates at intake (50 facilities) and 40.7 percent conducted psychiatric assessments (35 facilities).[38]

LIVING IN PRISON

Once prisoners with mental illness are in the system, prison officials must ensure that they receive the care they need. At a minimum, mentally ill prisoners need their medications: too often drug treatment is interrupted when prisoners are transferred between prisons or when lockdown prevents medication delivery. Prisons should also be responsive to changes in prisoners' mental health, including possible late onset of mental illness. Finally, special disciplinary procedures, housing, and programming should be considered in order to improve diagnostic and behavioral outcomes. Implementing these changes will help stabilize the conditions of mentally ill prisoners which, in turn, will both reduce suffering and improve long-term prognoses.

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[34] Eric Silver et al., Assessing Violence Risk Among Discharged Psychiatric Patients: Toward an Ecological Approach, 23 Law and Human Behavior 238 (April 1999), available at http://www.springerlink.com/(a3z4blvb5zk2ze4534j1yr3h)/app/home/contribution.asp?referrer=parent&backto=issue,5,8;journal,41,138;linkingpublicationresults,1:104390,1.
[35] Nieto at 2.
[36] Beck Study at 5.
[37] Id.

Unfortunately, the California prison system has proven itself incapable of addressing any of these issues. The prison mental health system suffers from many problems: chronic staffing shortages; lack of quality control and managerial oversight of mental health care providers; an emphasis on security that can be counterproductive for both security and treatment when dealing with the mentally ill; a badly outdated and unusable data system; and a dysfunctional medication disbursement system.

The CDCR has lost a number of lawsuits alleging grossly inadequate standards of care that violate the 8th Amendment's prohibition on cruel and unusual punishment.[39] In 1995, two class action suits were filed on behalf of mentally ill prisoners, Coleman v. Wilson and Madrid v. Gomez. Madrid's plaintiff class was limited to mentally ill inmates at the "supermax" facility at Pelican Bay, while Coleman's plaintiff class represented mentally ill prisoners in the rest of the system. The state lost both suits; as a result, certain reforms were ordered. The reforms have not addressed the issues in a manner sufficient to ward off further 8th Amendment claims, however; the CDCR recently lost a suit, Plata v. Schwarzenegger, alleging that the prison health system as a whole is so grossly inadequate as to constitute cruel and unusual punishment.[40] Currently, the prison health system is preparing to be administered through court-supervised receivership. Without addressing the serious and systemic problems with the administration of mental health care, California's Correctional System faces a future of more lawsuits and further judicial control.

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[38] Id.
[39] The grim picture is also substantiated by a number of both state- and privately-funded studies of the system. See, e.g., Ill-Equipped, Little Hoover 157, and Nieto.
[40] 2005 WL 2932253 (N.D. Cal 2005).

Currently, the system classifies mentally ill prisoners in an attempt to match levels of service to medical needs. Inmates who are capable of living in the general population are placed in the Correctional Clinical Case Management System (CCCMS). CCCMS inmates receive medication and counseling[41] and meet with their clinical case manager at least once every 90 days.[42] Prisoners "who are unable to function or care for themselves" in the general prison population "or who are acutely ill or decompensating" are placed in the Enhanced Outpatient Program, or EOP.[43] EOP provides regular medication review, meetings with a case manager at least once a week, and ten hours of structured therapy activities per week.[44] Finally, "patients in crisis" are housed in a Mental Health Crisis Bed in an infirmary on a short-term basis (10 days maximum).[45] Acutely ill patients who continue to remain in crisis beyond ten days are transferred to the custody of the Department of Mental Health.[46]

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 who need it. For example, the EOP serves 1-2 percent of the state prison population but fails to meet demand.[47] In 2002, San Quentin's EOP was operating at 385 percent of capacity, while the Valley State Prison for Women was at 156 percent capacity.[48] Prison policies require transfers into EOP to be completed within 30 days of a

[41] Nieto at 39.
[42] California State Prisoners Handbook at 262.
[43] Id.
[44] Id.
[45] Id.
[46] Id.
[47] Ill-Equipped at 131.
[48] Id.

recommendation by medical staff, but "most administrators acknowledge transfers can be delayed far longer".[49] We turn now to the reasons for these failures.

Staff Shortages. California prisons suffer both from inadequate hiring and inadequate retention, each of which contributes to the other. Understaffing drives people from the workforce; high turnover means recruiting is more difficult.

California prisons have a history of chronic psychiatric staff shortages. In the 1995 Coleman decision, the court observed that not only were current psychiatric positions understaffed, but that several studies for the decade prior had noted shortages as well.[50] Pelican Bay opened in December of 1989 without a single psychiatrist on staff.[51] A 1998 study found system-wide vacancies of 14 percent in the EOP.[52] Anecdotally, a California Medical Facility staff psychiatrist said that "turnover is huge" and "asserted that the average stay for mental health staff in the prison was a mere six months."[53] Staff shortages are not confined to mental health care: the prison system suffers a 15 percent vacancy rate for physicians, which does not account for "the additional significant percentage of incompetent doctors who need to be replaced."[54] Some prisons have an 80 percent vacancy rate for nursing staff.[55]

The remote location of most prisons makes recruitment more difficult, as do the low quality of services and the unprofessional environment.[56] Pay is also an issue: nurses in the prison system make between 20 and 40 percent less than in the private sector[57] and

[49] Id.
[50] Coleman at 1306-7.
[51] Madrid at 1214.
[52] Nieto at 39.
[53] Ill-Equipped at 98.
[54] Plata at 11.
[55] Id.
[56] Nieto at 44.
[57] Plata at 11.

29 percent less than Medical Technical Assistants, corrections officers who do jobs "that could be performed by licensed nurses."[58] The pay differential between medical staff and corrections officers has also been cited as another barrier to recruitment of qualified medical staff.[59] Insufficient staffing, while obviously degrading care, also increases costs: the transportation costs alone of sending prisoners to hospitals was $875 per prisoner per trip in 1998.[60]

Lack of quality control and management. The prison health care system lacks any meaningful way of measuring or managing the quality of medical care; at the same time, there is ample evidence that prisoners are getting grossly substandard care. This lack of management makes it almost impossible to fire, retrain, or reassign poorly performing staff.

The court in Plata v. Schwarzenegger held that the CDCR "lacks an adequate system to manage and supervise medical care".[61] The CDCR has a staggering 80 percent vacancy rate in the higher level of management of its Health Care Services Division (HCSD).[62] In September 2004, the prison healthcare system was ordered to implement quality management of physicians but "failed to come close" to doing so.[63] There is "a culture of non-accountability and non-professionalism" in the HCSD.[64] The Plata court noted that the system suffers from "organizational silo" syndrome: that is, there is no comprehensive, system-wide oversight, but rather a series of prisons accountable only to

[58] Nieto at 45.
[59] Ill-Equipped at 131.
[60] Nieto at 32.
[61] Plata at 3.
[62] Id. at 5.
[63] Id. at 2.
[64] Id. at 10.

their individual wardens.[65] Receivership is the court's attempt to improve the situation; interestingly, the medical service workers' union supports receivership.[66]

Inadequate Information Technology. Data management in the HCSD is "practically non-existent".[67] Without information, requisite patient treatment, quality control, and management are almost impossible to implement. Systems to track patient follow-up don't work,[68] and medical records in most prisons are "either in a shambles or non-existent."[69] Doctors often have to open new patient files because they can't find the old ones.[70] Medical records are not transferred from jails, parole, or from other prisons (in the case of inter-prison transfers).[71] 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."[72] That is, not only are prisoners not getting the care they need, managers are unable to diagnose and correct problems with incompetent staff. At a minimum, adequate records would help administrators to give prisoners timely access to drugs and treatment.

The CDCR's information technology deficits have been acknowledged for years. In 2004 the Corrections Independent Review Panel deemed the system's information

[65] Id. at 3.
[66] Id. at 33.
[67] Id. at 4.
[68] Id.
[69] 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.
[70] Id.
[71] Nieto at 16.
[72] Ill-Equipped at 102.

technology "inadequate".[73] A 1998 study found that medical records were compiled by hand.[74] Coleman in 1995 noted "extremely deficient" record keeping in the system at large[75], while the Pelican Bay records were described as "nothing short of disastrous" and "outrageously disorganized."[76] In 1992, the CDCR committed itself to the legislature to improve health care delivery, standardization, and automation via, inter alia, a Health Information Project.[77] CDCR officials later blamed their failure to implement these reforms on the state procurement process.[78]

Lack of coordination with and cooperation from Corrections Officers. Corrections officers ("CO's") could be a vital aid in the quest to improve treatment of mentally ill prisoners. CO's not only serve as a potential "early warning system" for changes in prisoners' behavior and mental health, they also distribute medications and accompany prisoners to medical clinics. CO's are an untapped resource in an area that desperately needs more resources; at the very least, CO's should not perform their duties in a manner counterproductive to prisoners' health, as such moves only increase costs and discipline problems in the long run.

CO's play too large a role in determining treatment for mentally ill prisoners, making medical decisions based on security considerations. According to Dr. Michael Friedman, director of medical care at Soledad Prison, "[t]he system, in my view, is totally corrupted" because "[n]onmedical staff are making medical decisions, because

[73] Report of the Corrections Independent Review Panel, Reforming Corrections (presented to Governor Schwarzenegger June 2004), available at http://cpr.ca.gov/report/indrpt/corr/report/11.htm, last visited Nov. 14, 2005).
[74] Nieto at 46.
[75] Coleman at 1314.
[76] Madrid at 1203.
[77] Nieto at 43.
[78] Id.

everything is about security, not how we look after the inmates."[79] Because corrections officers have daily contact with inmates, they could provide timely referrals for mental health treatment; however, CO's fears that prisoners are just malingering means that referrals are often not made until prisoners are grossly psychotic.[80] The Madrid decision noted that mentally ill inmates who were not displaying violent or disruptive behavior could remain untreated for "months."[81] Madrid also found that corrections officers 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."[82] Currently, corrections officers are inadequately trained: all get a three hour training in "unusual inmate behavior" which is occasionally supplemented by discretionary programs administered by their local prisons.[83] Corrections officers are often not available to take prisoners to their medical appointments; medical caregivers also report that CO's display a lack of respect for them that interferes with their ability to make decisions in the clinical context.[84]

CO's without adequate training in or sensitivity to the symptomology of mental illness end up over-committing mentally ill prisoners to administrative segregation. Mentally ill prisoners are disproportionately represented in administrative segregation: in July 2002, 31.85 percent of the California administrative segregation population was on the mental health caseload.[85] At Mule Creek State Prison, half of crisis beds came from

[79] James Sterngold, Grim Reality of Prison Health Care, S.F. Chron., Oct. 16, 2005, at A15.
[80] Ill-Equipped, 76 et seq.
[81] Madrid at 1217.
[82] Id. at 1219.
[83] Ill-Equipped at 77.
[84] Plata at 15. Note that this refers to all medical treatment, not psychiatric treatment in particular.
[85] Ill-Equipped at 148.

the EOP administrative segregation population.[86] At the Valley State Prison for Women, the figures were higher: 65.91 percent of the prisoners in secure housing were mentally ill.[87] This cycle can lead to the mentally ill being "trapped at the bottom"[88], never getting out of secure housing because "most people in isolation will fall apart."[89] Mental health care in administrative segregation is limited to drug treatments only: without therapy, face-to-face contact, and exposure to normalcy, recovery is difficult. "The requirement of isolation flies in the face of the medically accepted fact that most mentally disordered people need to interact with others."[90]

Decompensating prisoners sometimes become violent; one defense attorney reported that mentally ill clients of hers received third-strike convictions (hence life in prison) for in-prison offenses caused by untreated mental illness.[91] Fear of decompensating prisoners can also result in horrifying overreactions on the part of corrections officers. Madrid cited the example of one psychotic inmate being placed in water hot enough to give him severe burns.[92] Guards took the prisoner, who was African-American, into the infirmary and said in the presence of a nurse, "we're going to have a white boy before this is through."[93] After the prisoner was removed from the water, the nurse testified that "his skin had peeled off and was hanging in large clumps around his legs, which had turned white with some redness."[94]

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[86] Id. at 160.
[87] Id.
[88] Id. at 154.
[89] Id. at 149.
[90] Id. at 155.
[91] Id. at 66.
[92] Madrid at 1166-67.
[93] Id. at 1167.
[94] Id.

Medications problems. Abrupt withdrawal from psychotropic medications can lead to relapses, panic attacks, and psychosis,[95] yet many prisoners face precisely these terrifying symptoms because the medication delivery system is broken. Management of medication is "unbelievably poor."[96] There are no timely refills for prisoners with chronic conditions;[97] unmedicated prisoners can eventually grow "too far gone" to request their medications.[98] Prison policies state that prescriptions must travel with 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."[99] Prescriptions from other prisons are, in fact, routinely disregarded.[100]

For those prisoners who do get their medications, the system provides disincentives to continued medical treatment. Certain medications, for example, induce anxiety as a side effect unless taken just before sleep, yet nighttime deliveries for these medications are not permitted.[101] 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.[102] Given that these drugs are medically necessary and readily available outside prison, such a policy is completely nonsensical. Side effects to some psychotropic medications are quite substantial, even when taken as directed, but California has done little[103] to monitor

[95] Ill-Equipped at 118-9.
[96] Plata at 16.
[97] Id.
[98] Ill-Equipped at 120.
[99] Plata at 16.
[100] Id.
[101] Ill-Equipped at 117-8.
[102] Id. at 126.
[103] Id. at 120.

and ameliorate side effects other than those relating to heat-sensitivity.[104] Prisoners who opt out of taking drugs cannot be forced to take them without officials following a Byzantine process,[105] yet CO's and health officials make little effort to convince prisoners who have decided to stop taking their medicine to reconsider.[106] Once again, systemic problems with refill delays, the lack of medication continuity upon transfer, and a failure to monitor side effects were identified as early as 1995 in the Coleman litigation.[107]

RELEASE

Release is inevitable for all but a small fraction of mentally ill prisoners; prisons should therefore plan for release of these prisoners as early as is feasible.[108] Approximately 66,000 prisoners are released in California each year. In 2002, the Legislative Analysts' Office estimated that approximately "12,000 of the offenders released from prison with a documented history of psychiatric problems are on state parole caseloads."[109] Parole Outpatient Clinics (POC's) provide assistance to 9,000 of

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[104] Id. at 124.
[105] California State Prisoners Handbook at 265-66.
[106] Ill-Equipped at 125.
[107] Coleman at 1309.
[108] Prison release dates are known with some degree of certainty. Unfortunately, jails do not lend themselves as easily to careful release planning, since 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.
[109] California State Legislative Analyst's Office, Analysis of the 2000-01 Budget Bill: Linking Mentally Ill Offenders to Community Care, available at http://www.lao.ca.gov/analysis_2000/crim_justice/cj_2_cc_mentally_ill_anl00.htm (last visited Nov. 15, 2005). 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 7/2001 and 12/2003, for an average of 19,316 per year (of whom 79.8% are CCCMS, 14.2% EOP, and 6% are unclassified.) See Third Annual Report on the Mental Health Services Continuum Program of the California Department of Corrections and Rehabilitation—Parole Division, prepared by the UCLA Integrated Substance Abuse Program Neuropsychiatric Institute 14 (June 30, 2005) (hereinafter "2005 MHSCP Report").

these individuals.[110] If intake is about diagnosis and life in prison is about holding the line, release prepares prisoners so that they can stabilize their condition outside prison and, one hopes, avoid recidivism. Recidivism can be reduced if re-entry is planned, intervention is front-loaded and addresses multiple issues, 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 ultimately reduce strains on the prison system and its budget—by decreasing prisoner recidivism, more resources are freed up within the system, and society as well as individual prisoners pay far less in other costs.

The most effective post-release programs concentrate on the period immediately following release and address multiple issues such as mental health, parole, therapeutic treatment, housing, and/or employment (the "integrated services" model).[111] For example, prisoners about to be released should have an adequate supply of medication (at least 72 hours' worth), some form of housing, and contacts with a coordinated team of correctional and social services staff to help him as he enters parole, seeks permanent housing, pursues job training and employment, enrolls in drug and alcohol abuse counseling, and restores government benefits (TANF, Medical, Medicaid, Social

[110] Id. These numbers must be taken with a grain of salt: sex offenders are required to report to POC's, 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 percent, to use the most conservative estimate—that means almost 7,000 prisoners with serious mental illnesses will be released on average per year. Of the non-serviced individuals, one can only hope that they are high-functioning. According to a 2004 report, the priority for POC services, from high to low, is EOP parolees, those from Mental Health Crisis Bed (stabilization for 10 days), DMH releases (e.g. CONREP), CCCMS getting only clinical treatment, CCCMS not on meds and no clinical treatment within 6 months of release. 2005 MHSCP Report at 8.

[111] Back to the Community: Safe & Sound Parole Policies, Little Hoover Commission Report 172, at x (November 2003), available at http://www.lhc.ca.gov/lhcdir/report172.html (hereinafter "Little Hoover 172").

Security, Disability).[112] Treatment should employ cognitive behavioral techniques, emphasize positive reinforcement, use actuarial assessments and be based in the community.[113] It's not enough to threaten to be "tough" on parolees—threats don't seem to work "because they do not target for change the known predictors of recidivism."[114]

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 relying on self-reporting, 22 percent of parolees had their parole revoked for failure to report, 16 percent for drug violations, and 18 percent for other reasons such as failure to meet financial or employment conditions.[115] In San Francisco, for example, 94 percent of mentally ill offenders on parole have their parole revoked and are returned to prison.[116] 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 percent.[117] An over-emphasis on the goal of abstinence could be the common thread between the two.[118]

The CDCR should aim to reduce parole revocations that are a function of untreated mental illness, a focus that does not in any way jeopardize its ability to protect public safety. Mentally ill parolees can obviously be sent back to prison for committing

[112] Mentally ill prisoners report high rates of homelessness, unemployment, and drug use prior to incarceration. Ditton Study at 5.
[113] Joan Petersilia, What Works in Prisoner Re-Entry: Reviewing and Questioning the Evidence, Federal Probation, September 2004, at 3-4.
[114] Id. at 4.
[115] Petersilia, When Prisoners Come Home at 149. See also Shield at 4.
[116] Sonja Shield, Center on Juvenile and Criminal Justice, Addressing Gaps in Post-Release Services for Mentally Ill Offenders: One Community's Response, 2 (2003), available at http://www.cjcj.org/pdf/mentally_ill.pdf.
[117] When Prisoners Come Home at 84 (citing Petersilia and Turner's 1993 study).
[118] Shield at 5.

new crimes, and those who decompensate to the point where their illness is acute can also have their parole revoked: as the standard form for conditions of parole states, "When 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."[119] Parole Officers must report to the Parole Board if a parolee's mental condition deteriorates "such that the parolee is likely to engage in future criminal behavior."[120] Parolees can be returned to prison under an "Emergency Transfer" if they meet the criteria for mental illness and "if he or she cannot receive necessary psychiatric treatment pending a hearing".[121] While parolees must be returned upon a finding of future criminal behavior, they can also be returned if they have a mental disorder "which substantially impairs his or her ability to maintain himself or herself in the community" and "necessary psychiatric treatment cannot be obtained in the community."[122]

At the same time, prisoners with acute mental illness should continue to be released into treatment, not parole, through the Mentally Disordered Offender (MDO) program. A prisoner is classified as an MDO if he or she has a severe mental disorder that is not in remission, if the disorder was either one of the causes of or an aggravating factor in a crime involving force or violence, and he or she poses a substantial danger of

[119] California State Prisoners Handbook, Appendix 10-A (Supp. 2004).
[120] Cal. Code Regs. Tit. 15 §2616(a)14.
[121] Cal. Code Regs. Tit. 15 §2605(c).
[122] Cal. Code Regs. Tit. 15 §2637(b)6. Note, however, that the legality of this regulation is in dispute (at least the portions of §2637 which apply to sexually violent predators). A state Court of Appeal 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 (1998).

physical harm to others.[123] MDOs are released into inpatient treatment at state mental hospitals as a condition of parole when their prison term expires.[124] Once the offender's hospital treatment team and officers of the Conditional Release Program (CONREP) believe a patient can be safely and effectively treated on an outpatient basis, the Department of Mental Health will recommend treatment in CONREP.[125] CONREP provides full mental health services (including individual and group therapies, substance abuse screenings and psychological assessments) and provides a return mechanism to state hospital inpatient status for participants who do not comply with their treatment plan.[126] MDO participants can be forced to continue treatment at the end of their parole terms if they continue to have severe mental disorders, if these disorders are not in remission or cannot be kept in remission without treatment, and if they continue to pose a substantial danger of physical harm to others.[127] In such circumstances, the DMH will refer the case to the District Attorney, who will then initiate proceedings.[128]

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

[123] Cal. Penal Code §2960 et seq.
[124] California State Prisoners Handbook at 407.
[125] Cal. Welf. & Inst. Code §4360 et seq.
[126] See California Department of Mental Health, Forensic Conditional Release Program, http://www.dmh.ca.gov/Forensic/conrep.asp (last visited Dec. 20, 2005).
[127] Cal. Penal Code §2970. See also People v. Beeson, 99 Cal. App. 4th Supp. 1393 (2002) (describing an MDO commitment proceeding).
[128] California State Prisoners Handbook at 411.

shortcomings and to shift managerial and material resources to where they are most needed.

The Mental Health Services Continuum Program (MHSCP): Transition from Prison to Parole. MHSCP is a statewide program designed to ease mentally ill inmates' transition from prison to parole and thereby reduce recidivism.[129] It serves parolees released on or after October 1, 2000.[130] 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.[131]

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 90 days of the inmate's Earliest Possible Release Date (EPRD).[132] The assessment is then updated within 30 days of the EPRD and the information is entered into the Parole Automated Tracking System database.[133] A first post-release appointment is also scheduled—within three business days for EOP parolees and seven business days for stable, functioning CCCMS parolees.[134]

A 2005 study of MHSCP participants from July 1, 2001 to December 31, 2003 showed promising results. Participants in the program were much more likely than non-participants to attend Parole Outpatient Clinics (POC's) and less likely to return to prison.

[129] 2005 MHSCP Report at 1.
[130] Id.
[131] Id.
[132] Id.
[133] Id.

Assessment alone appeared to be a factor in improving post-release POC attendance: 66.2% of assessed inmates attended at least one POC session, compared to 50.8% of non-assessed inmates.[135] Assessed inmates also attended more POC sessions, on average, than non-assessed inmates did: a mean of 4.4 versus 3.3.[136] Most significantly, pre-release assessments were associated with a 19% reduction in the likelihood of being returned to custody in the first 12 months of release, and having at least one POC contact was associated with a 37% reduction in recidivism risk.[137] 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.[138] Parolees attending at least one POC session saved the CDCR $5,998 per EOP parolee and $3,224 per CCCMS parolee.[139]

MHSCP's main shortcoming is that not all eligible prisoners are actually reached by the program. Only 57% of the eligible pool of released prisoners were assessed in a face-to-face meeting prior to release.[140] In some instances, prisoners were not assessed because they were not listed early enough on the Offender Information Services (OIS) list of soon-to-be-released inmates.[141] 63.5% of MHSCP-eligible inmates appearing on the list more than 45 days before their release date were assessed face-to-face;[142] however, of the 14.3% of MHSCP-eligible inmates who appeared on the OIS list within 45 days of

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[134] Id. at 1-2. Again, CCCMS parolees are diagnosed with mental illness but stable functioning; EOP parolees are diagnosed with acute onset of a serious mental disorder with delusional thinking, hallucination, etc. See discussion supra at 12.
[135] Id. at 2.
[136] Id.
[137] Id. at 3.
[138] Id.
[139] Id.
[140] Id. at 2, though the report notes hopefully that "the percentage of inmates who are assessed has increased over time."
[141] Id.

release, only 17.8% got a face-to-face assessment.[143] Assessment rates have been improving recently; it remains to be seen whether the program can continue to reach more and more prisoners.

Mentally Ill Offender Crime Reduction Grant Programs. The California Mentally Ill Offender Crime Reduction Grant (MIOCRG) program was established in 1998 to fund innovative programs targeting mentally ill offenders. This program funds 30 projects in 26 counties (over 80 million dollars).[144] Counties were asked what their needs were in dealing with mentally ill offenders, and they responded that they needed better discharge planning, more housing options, increased treatment capacity, and interagency coordination.[145] The programs funded take this into consideration. Two-thirds of the programs draw on Assertive Community Treatment (ACT) model,[146] employing a multidisciplinary group of providers that service clients as a team, with availability around the clock. Programs are administered on a county level with money from the state, allowing for better coordination with mental health services (which are county-based) without encountering resource differentials between counties. However, most counties exclude violent offenders from their programs.[147] This makes little sense from any perspective except stigma: violent offenders, if still violent, will be treated under the MDO and CONREP programs. If people who were imprisoned on a violent offense show no signs of current or future dangerousness, they need treatment. Put another way,

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[142] Id.
[143] Id.
[144] 2005 MIOCRG Report at 1.
[145] 2004 MIOCRG Report at 4.
[146] 2005 MIOCRG Report at 1. ACT criteria include multidisciplinary staffing, integration of services, low client-staff ratios, 24-hour access, and time-unlimited services (that is, ongoing treatment on an as-needed basis, even after participants' conditions have stabilized).
[147] Id. at 2.

these offenders aren't going away. If they are not treated, what do counties that exclude them expect to happen?

A study aggregating data from the programs showed positive results.[148] Participants showed improved General Assessment of Functioning (GAF) scores[149] and lower rates of criminal bookings, convictions, drug and alcohol usage, and homelessness.[150] The most effective strategies common to all programs were interagency collaboration, intensive case management, involvement of the courts, mental health courts, assistance securing benefits, assistance arranging housing, medication management, use of a center or clinic, assistance with transportation, and peer support for participants.[151]

Programs targeting the mentally ill homeless. California has also targeted the mentally ill homeless through a variety of state initiatives, commonly referred to as AB 2034 programs.[152] These programs serve, but do not specifically target, mentally ill ex-offenders who are homeless. Pilot programs funded by AB 2034 reduced days of incarceration by 72.1% and the number of incarcerations by 45.9%.[153] Participants' ability to secure housing was a real 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

[148] 2004 MIOCRG Report at 3.
[149] 2005 MIOCRG Report at 5.
[150] Id. at 4.
[151] Id. at 7. Many of these factors track closely with the ACT criteria, supra note 160.
[152] Stephen Mayberg, Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Division 5, Section 5814, of the California Welfare and Institutions Code note at i (2003), available at http://www.dmh.cahwnet.gov/AOAPP/Int_Services/docs/AB2034_may2003.pdf.
[153] Id. at 10.

desire to make progress in other aspects of their lives."[154] 2034 programs also treat co-occurring substance abuse—61.9% of program participants had a co-occurring substance abuse disorder, and 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."[155] 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."[156] Outcome measurements for programs include current housing and employment—an outcome focus unique to this program.[157] As of 2003, AB 2034 programs served 5,000 people, about 10% of the estimated 50,000 mentally ill homeless people in California.[158]

Graduated Sanctions and Harm Reduction. One San Francisco program funded by AB 2034 uses graduated sanctions within a harm reduction philosophy—that is, drug violations do not automatically result in parole revocation.[159] Harm reduction recognizes abstinence as the ultimate goal, but "accepts that not everyone is ready or able to cease all drug use immediately."[160] Drug abuse is treated according to a disease model, not a criminal one. As one program administrator says, "Everyone agrees abstinence is the

[154] Id. at 2.
[155] Id. at 8.
[156] Id. at 22. 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.
[157] Id.
[158] Id. at 36.
[159] Shield at 3.
[160] Id. at 5.

ideal. But that is not going to happen, so let's not make them flee from treatment."[161] One method of getting patients to reduce dependence on illegal drugs is to educate them about symptom management (which they might be self-medicating through illegal drug use) and about the benefits of legal medications.[162] When a client relapses, the graduated sanctions approach means that administrators respond by adjusting treatment first, rather than immediately revoking parole.[163] The program also reaches out 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."[164]

Parole officers, however, are constrained by Parole Board violation policies in their ability to participate in programs using harm reduction and graduated sanctions: officers are still officially required to report certain offenses.[165] Official parole policies will therefore have to change if harm reduction and graduated sanctions are to be rolled out on a large-scale basis. Parole officers are also hindered by the prospect of liability, which affects their ability to take chances on a given client.[166] Indemnification of parole officers participating in certain programs might improve outcomes and could be paid for out of the cost savings from implementing graduated sanctions. 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": treating drug abuse with graduated sanctions was estimated to save $151 million immediately, while reducing the

[161] Id. at 6.
[162] Id. at 6-7.
[163] Id. at 7.
[164] Id. at 8-9.
[165] Id. at 10. See, e.g., Cal. Code Regs. Tit. 15 §2616.
[166] Petersilia, When Prisoners Come Home, at 85 et seq.

average revocation sentence from 140 days to 100 days was estimated to save $300 million per year.[167]

POLICY RECOMMENDATIONS

Without a change in the culture of the CDCR health care system, any 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 paper 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. If this culture of failure is eliminated, several other specific changes must also be implemented: some form of diversion from the penal system; a flexible, fully-funded, coordinated provision of care in prisons, including information systems and managerial oversight designed to ensure compliance with standards of care; an expansion of programs targeting the mentally ill and specific subgroups therein; and an expansion of post-release programs as outlined above.

I. Promote alternatives to prison.

Because people with mental illness tend to get sicker in prison, all efforts should be made to divert them from the penal system 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, treating mental illness as a public health problem irrespective of whether the person with mental illness is in prison or outside it.

Diversion saves money and improves outcomes. Imprisoning the mentally ill is a very expensive proposition; California can either spend the money incarcerating the

[167] Little Hoover 172 at iii. These figures are for parolees in general, not just mentally ill parolees.

mentally ill or serving a larger number of patients more efficiently and effectively in a non-penal context. Diversion can be explored whenever the mentally ill come into contact with the criminal justice system. Police can be trained in de-escalation techniques and can be encouraged to refer the individuals they encounter to the DMH, where appropriate; 911 dispatchers can also send trained mental health professionals to respond to calls believed to have a mental health component.[168] Before trial, the mentally ill can be diverted from prosecution into treatment or from criminal court to a mental health court.[169] Mental health courts in particular, by combining law enforcement and social services in a therapeutic approach, have proven particularly effective. As of 2002, 13 trial court systems in California had established mental health courts;[170] additional courts will be funded as a result of Proposition 63 (discussed infra at 64).

Diversion can only work if non-penal forms of mental health treatment get greater resources; currently, the non-penal mental health infrastructure is vastly underfunded and underutilized. California's mental health treatment system began to atrophy during the 1950's, when the deinstitutionalization movement proposed to treat people with mental illness in the least restrictive setting.[171] From 1955 to 1994, California saw its population of state mental patients decrease by 89.8 percent; adjusting for increases in the state's population, however, yields a figure closer to 96 percent.[172] In other words, 96 percent of

[168] Diversion policy recommendations for law enforcement are discussed in detail in Chapter 2 of the Criminal Justice/Mental Health Consensus Project; see Council of State Governments, Criminal Justice/Mental Health Consensus Project 34 et seq. (June 2002), available at http://consensusproject.org/the_report/.
[169] Consensus Project at 72 et seq.
[170] Mental Health Courts, Judicial Council of California Collaborative Justice Programs, available at http://www.courtinfo.ca.gov/programs/collab/mental.htm, last visited Jan. 26, 2006.
[171] See generally E. Fuller Torrey, Out of the Shadows: Confronting America's Mental Illness Crisis (1997).
[172] Id., excerpted at http://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html (last visited Jan. 26, 2006).

the people who would have received inpatient treatment in state mental hospitals in 1955 are now elsewhere.

At the same time, California's civil commitment laws 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.[173] Commitment, known as a conservatorship, lasts for a year; conservatorships can be renewed but, if challeneged 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 initially refuse treatment even if they might be too mentally ill to exercise sound judgment (making "voluntary" refusals to accept treatment more suspect[174]), and second, the law allows for commitment only after the illness has reached a crisis point.[175] 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 need care."[176]

The lack of access to voluntary care and the difficulty of coercing treatment has led some to posit a "balloon theory": by making it harder to treat illness in a civil context,

[173] Cal. Welf. & Inst. Code §5000 et seq.
[174] 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 at 15 (April 7, 2003 draft for Health Affairs).
[175] California Treatment Advocacy Coalition, Fact Sheet: TALKING POINTS—Why LPS Must Be Reformed, available at http://www.psychlaws.org/StateActivity/California/factsheet1.htm (last visited Dec. 19, 2005).

the mentally ill shift to context where they can be coerced into treatment and where treatment must be provided: prison.[177] Untreated mental illness may manifest itself in behavioral problems that result in arrest and imprisonment,[178] 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.[179] This might explain why the incidence of extreme recidivism among inmates—those inmates with 11 or more prior offenses—is twice as high for the mentally ill.[180] The ironic result is that a deinstitutionalization policy borne of a desire to treat the mentally ill using the least restrictive alternative now puts them in the most restrictive environment possible.[181] For diversion to work, there must ultimately be greater resources devoted to non-penal alternatives and better legal mechanisms for steering people with mental illness toward treatment.

One path towards getting greater resources for prisoners might be to tap into the money generated by various state and federal initiatives. California Proposition 63 (codified as the Mental Health Services Act, or "MHSA"), which raises money for the treatment of the mentally ill via a tax on those with incomes greater than one million dollars, has not yet been used to fund programs relating to mentally ill prisoners in

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[176] Being There: Making a Commitment to Mental Health, Little Hoover Commission Report 157 at iii (November 2000), available at http://www.lhc.ca.gov/lhcdir/report157.html (last visited Jan. 26, 2006) (hereinafter "Little Hoover 157").
[177] That is, push down on one part of the balloon—hospitalization—and the needs of people with mental illness will arise in a different location—prison.
[178] Kanapaux, Guilty of Mental Illness at 2.
[179] See Kanapaux at 6; see also Frequently Asked Questions from Frontline: the New Asylums (PBS television broadcast, May 2005), available at http://www.pbs.org/wgbh/pages/frontline/shows/asylums/etc/faq.htm (quoting Reginald Wilson, director 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.'").
[180] Frontline Frequently Asked Questions.
[181] This phenomenon—the transition from inpatient treatment in hospitals to incarcerated treatment in prisons—is known as transinstitutionalization.

particular.[182] It is unclear whether this is a result of a policy decision or simply the lack of knowledge on the part of corrections officials—the information given to potential applicants identifies a goal of funding co-occurring mental illness/drug addiction treatment, but it does not list corrections anywhere.[183] The closest the MHSA comes is citing, as one of its goals, "to reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness."[184] The funds available through the MHSA are significant—in excess of $600 million a year,[185] or about a 26 percent increase over current funding levels.[186]

Perhaps the most radical, and most useful, reform would be to treat mental illness as a public health problem, not as a criminal problem, regardless of the custodial status of those involved. Such an approach would encompass graduated sanctions and harm reduction in parole, but would also extend to other factors as well. For example, if prisoners who suffer from mental illness were treated through Medi-Cal or Medicaid, administration costs would decrease and continuity of care would be improved. Prisoners would no longer need to face medication and therapeutic shortages as they got lost in the shuffle. Given that the courts will be administering the prison health care system receivership, shifting care from the CDCR to Medi-Cal makes sense. Moreover, given

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[182] Sadly, this oversight is not uncommon. The recent report published by in 2003 the President's New Freedom Commission on Mental Health makes no mention of the mentally ill behind bars. See supra note 7. Apparently reducing the stigma of mentally ill is a goal only if the mentally ill in question are not further stigmatized by their criminal records.

[183] Proposition 63 Information Kit, California Judicial Council 3 (August 2005), available at http://www.courtinfo.ca.gov/programs/collab/documents/prop63infopack.pdf.

[184] Mental Health Services Act § 3(b) ("Purposes and Intent"); available at http://www.dmh.cahwnet.gov/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf, last visited 1/26/06.

[185] Proposition 63 Information Kit at 1.

[186] Kara Bambauer, Proposition 63: Should Other States Follow California's Lead?, 56 Psychiatric Services 642 (June 2005). On a federal level, the Mentally Ill Offender Treatment Crime Reduction Act (signed into law October 30, 2004), also provides $50 million in grants for, inter alia, improving mental health and substance abuse care to prisoners and those re-entering society.

the high rates of communicable diseases such as AIDS and Hepatitis in the prison community,[187] coupled with the fact that prisoners do eventually return to society, an epidemiological approach that treats prison populations as a subset of the larger population could gain traction.

To implement such an approach, society at large would have to move away from certain entrenched ideas: that treatment of mental illness is somehow a fringe benefit (rather than a sound investment in public safety, the public fisc, and reduction of suffering) or that the mentally ill somehow stop being ill once they are incarcerated. A look at recent mental health initiatives, many of which exclude mentally ill offenders, indicates that there is a great need for leadership and education on this issue. But the fact that some people with mental illness commit crimes as a result of their mental illness does not make them less sick—and, as noted supra at 25, fears about letting dangerous offenders "out on the streets" can be addressed by reference to the state's MDO program, which covers violent mentally ill prisoners. Ideally, the state would include ex-offenders convicted of violent crimes in mental health programs once the individual had shown he or she was not currently dangerous.

On a related note, the state (and federal government) should stop excluding drug offenders from benefits. Abstinence is less effective than graduated sanctions; the harm from interruption of therapeutic programs far outweighs the minimal deterrence factor (a factor which is even smaller for the mentally ill). Excluding drug offenders from housing only makes them more likely to wind up homeless or in jail, at a cost that is greater both financially and in terms of human suffering. If the state's goal is public safety and

[187] See, e.g., Laura Maruschak, Bureau of Justice Statistics, U.S. Dept. of Justice, HIV in Prisons and Jails 1999 1 (July 2001) (finding nationwide rates of HIV infection in prison to be 5 times the rate of the

economy, excluding drug offenders from housing and other benefit programs for life makes very little sense and actually makes funding residential drug and alcohol treatment much more difficult.[188] Graduated sanctions for parolees, as mentioned earlier, could save California $151 million immediately.[189]

II. Implement a flexible, fully-funded, coordinated mental health program in prisons that uses data and management oversight to ensure quality care is provided.

Care needs to be flexible to accommodate the needs of prisoners, funding needs to be secured to ensure that prison health care and programming is fully staffed, corrections officers need to coordinate their priorities and operations to ensure that needless suffering is avoided, and information technology and management systems need to ensure that programs are providing positive outcomes.

First, the state's information technology and data collection needs to be revamped. Without better information, an accurate diagnosis of the system's ills is impossible. In general, more data needs to be standardized and shared, both within the prison system and among social service providers. Sharing information avoids duplication of effort (realizing some efficiency gains in a resource-strapped system), but also means that prisoners don't have to wait for treatment. This is especially important for mental illnesses, since a little decompensation goes a long way. Jails and prisons in particular must integrate their information, since there is so much population migration between the two systems. The state should consider funding mental health screening at the county level in jails: this would prevent duplication of screening in prison (upon

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population as a whole).
[188] When Prisoners Come Home at 125.
[189] Little Hoover 172 at iii.

inmate transfer) and would standardize the information collected.[190] Standardized information is of great assistance in maintaining effective release programs.[191]

For those prisoners with existing diagnoses, information must be shared between jails and prisons, or between social service providers and prisons. If the prisoner has been on medications outside the prison, every effort should be made to continue the identical medication; though many drugs perform the same function, side effects can be different. Since most patients' dissatisfaction focuses on the side effects of drugs, not their intended effects, changing drugs will be both disorienting (in an already disorienting environment) and may lead to a decreased willingness to take medication.

California needs to track county inmates, state prisoners and parolees with mental illness across jurisdictions. The state should consider piggybacking mental health information on one of the existing criminal justice databases—e.g. the Parole Automated Tracking System or the California Law Enforcement Telecommunications System (which tracks criminals across jurisdictional lines)[192]—or apply for funds from the National Criminal History Improvement Program to computerize criminal history records.[193] 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.[194] Ultimately, the information should be used to assess program effectiveness on an outcome basis.

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[190] Nieto at 47.
[191] John Monahan, Comprehensive Handbook of Psychology, Volume 11, Ch 24, at 25 et seq. (unpublished draft of 2001, on file with author).
[192] Nieto at 47.
[193] When Prisoners Come Home 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.
[194] Reforming Corrections at 1 et seq.

The prison system must also screen prisoners to account for late-onset mental illness. California needs to recognize that prison triggers mental illness in some inmates who do not (or did not) present symptoms at the time of intake, and protocols should be developed to ensure that late onset mental illness is identified and treated. Finally, California must revamp its prison health system in order to comply with the rulings of Judge Henderson in Plata. This will include, but is not limited to, streamlining administrative procedures to ensure easier access to treatment and implementing systems for more accountability on the part of service providers.

Second, resources for mental health treatment and programming in prison need to be expanded. It is clear that mentally ill prisoners do not get the care that they need. One collateral effect of resource scarcity is that there are fewer resources to address inmates with non-acute psychological needs. "Inmates 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."[195] One ingenious solution proposed to deal with staffing shortages would be to condition state medical education grants (or reduced rates on student loans) on recipients' agreeing to work in prison health care for a set period of time.[196] In addition to providing needed services, the community at large would benefit from improved information flow about what is really happening inside California's prisons.

Third, treatment can be improved by decentralizing its provision; prisoners are less likely to fall through the cracks if they can be treated in their "home" prison. California concentrates treatment in a few facilities, such as the California Medical

[195] Grim Reality at A16.
[196] Nieto at 48.

Facility in Vacaville (42.3 percent of inmates are in 24-hour care, receive therapy/counseling and take psychotropic medications) and the California Institution for Women (46.1 percent of inmates in therapy/counseling, 30.7 percent on psychotropic medications).[197] Decentralization of treatment may yield better results: local treatment facilities capable of handling mental illness might provide greater flexibility to prison administrators and less disruption to mentally ill inmates, although decentralization might simply strain already scarce resources.

Fourth, health care providers should enlist corrections officers to be first responders in the treatment of mental illness. CO's should receive more support and training for dealing with mentally ill prisoners, including training on mental health symptomology and pharmaceutical treatment. Other jurisdictions have experimented with different ways of imposing discipline on mentally ill prisoners to positive effect: behavior modification techniques engender order without as much confrontation as traditional techniques and seem to work better with mentally ill inmates, whose impulse control is not well established.

III. Tailor programs to the mentally ill population.

Programming needs to be expanded for mentally ill prisoners, and alternatives to standard policies, where appropriate, should be developed. This includes the possibility of separate housing for the mentally ill, separate disciplinary procedures, and an expansion of tailored post-release programs. Furthermore, individual subpopulations of mentally ill prisoners, particularly female prisoners with mental illness, need programming tailored to their needs.

[197] Ditton Study at 7.

Existing programs for the general population that are particularly effective for the mentally ill need to be identified and mentally ill prisoners need to be placed in them. At the same time, programming that is designed specifically for the mentally ill needs to be developed and implemented. These programs must address not only post-release needs (job skills, information about federal and state post-release programs, self-care) but deeper psychological needs as well. Prisoners with co-occurring drug and alcohol abuse need to be targeted, since their rate of recidivism is much higher than that of either the mentally ill or the general prison populations. Moreover, many mentally ill prisoners have suffered from emotional, physical, and sexual abuse; counseling to address the legacy of abuse and help prisoners avoid becoming abusers themselves should also be developed and implemented.

Safety, discipline, and housing also need to be modified to reflect the reality of mentally ill prisoners. 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, as discussed supra at 4, is often solitary confinement—either as punishment or protective custody. Given the harsh, decompensating effects of solitary confinement, alternatives to solitary confinement must be developed. On a more general level, housing of the mentally ill should be done with their needs in mind. Some inmates should not be housed with the general population, both for their safety and for the safety of those around them. They might benefit from a regime in which somewhat less traditional disciplinary rules prevail—this would avoid the cycle of violations and solitary confinement without sacrificing officer safety.

Female prisoners are particularly susceptible to depression as a result of separation from children and family: 10-15 percent of women entering reception centers suffer from depression.[198] Women prisoners with mental illness report more disciplinary violations than male prisoners: women on psychotropic medication have infraction rates twice that of other women prisoners, and higher than that for medicated men.[199] Programs and training should focus on the particular needs of women prisoners in the penal context.

IV. Eliminate the Culture of Failure

All parties with any involvement in the corrections system need to acknowledge openly that these problems have existed for several years, and that the system needs major overhaul. It is shameful that ten years ago, in the Coleman decision, the system was described in words that could apply with equal force today: "Defendants have been 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."[200] 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, and yet year after year, nothing seems to change except the dates on the latest atrocious review of CDCR policies. Litigation of these issues is expensive and removes any discretion from corrections officials—while this is a better alternative than keeping control in the hands of incompetent officials, it would be better still to address the problems proactively. Perhaps the department could begin publishing a shame table of the worst facilities, in

[198] Nieto at 22.
[199] Ill-Equipped at 39.

terms of untreated prisoners and abuses. Or the system could provide incentives for honesty in reporting mental health problems so that accurate information—the predicate to any solution—can finally be obtained. But even these suggestions have been made before.

It is therefore with some frustration that I conclude this paper, by noting that none of these recommendations is particularly novel. 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 another period in receivership, one can hope that lessons will finally be learned. The citizens of California—not merely its mentally ill prisoners—certainly deserve no less.

[200] Coleman at 1311.