Stanford Law School
Three Strikes Project

LDF
DEFEND EDUCATE EMPOWER

When did prisons become acceptable mental healthcare facilities?

Co-Published by:

California State Senate pro Tem, Darrell Steinberg
Stanford Law School Professor, David Mills
Stanford Law School Three Strikes Project Director, Michael Romano

Introduction

Senator Darrell Steinberg and Professor David Mills

We can no longer ignore the massive oppression we are inflicting upon the mentally ill throughout the United States. Over a century ago, Dorothea Dix began a movement to improve the deplorable conditions of mentally ill prisoners. Despite her success in changing the country's perception and treatment of the mentally ill in prison, we are now right back where we started in the nineteenth century. Although deinstitutionalization was originally understood as a humane way to offer more suitable services to the mentally ill in community-based settings, some politicians seized upon it as a way to save money by shutting down institutions without providing any meaningful treatment alternatives. This callousness has created a one-way road to prison for massive numbers of impaired individuals and the inhumane warehousing of thousands of mentally ill people.

Cages for mental health group therapy treatment, Mule Creek State Prison, February 7, 2013.

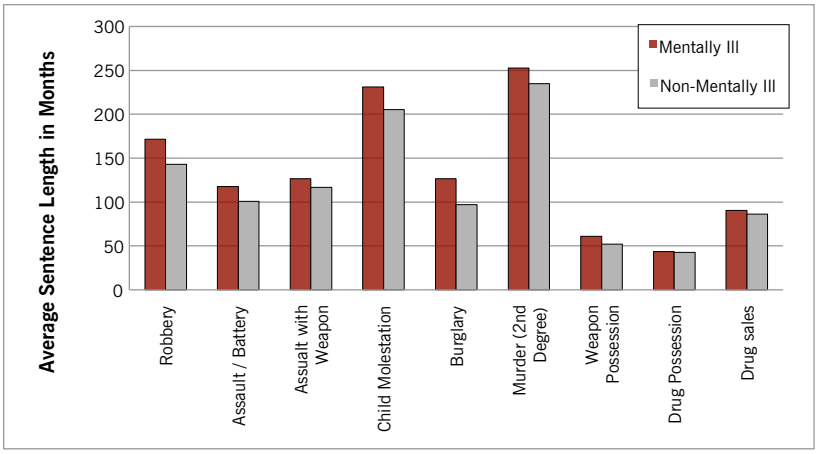
We have created conditions that make criminal behavior all but inevitable for many of our brothers and sisters who are mentally ill. Instead of treating them, we are imprisoning them. And then, when they have completed their sentences, we release them with minimal or no support system in place, just counting the days until they are behind bars once again. This practice of seeking to save money on the backs of this population comes with huge moral and fiscal cost. It is ineffective because we spend far more on imprisonment of the mentally ill than we would otherwise spend on treatment and support. It is immoral because writing off another human being's life is utterly contrary to our collective values and principles.

In San Francisco County Mental Health Court, prosecutors, defense attorneys, and judges work collaboratively to design treatment plans for mentally ill defendants. Photo courtesy of Loteria Films.

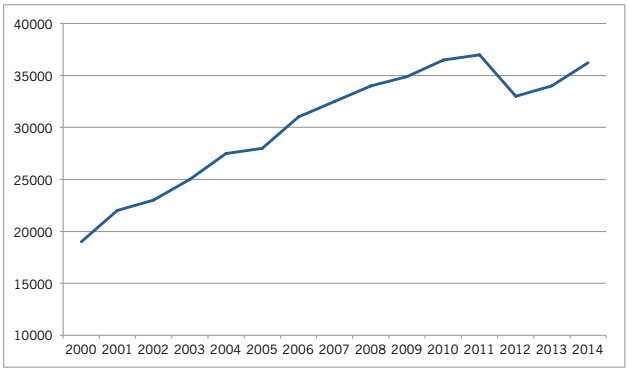
The numbers are staggering: over the past 15 years, the number of mentally ill people in prison in California has almost doubled.[1] Today, 45 percent of state prison inmates have been treated for severe mental illness within the past year. The Los Angeles County Jail is "the largest mental health provider in the county," according to the former official in charge of the facility.[2]

California was at the forefront of the spiral towards imprisonment rather than treatment, when it turned its back on community based mental health programs. As usual, what started in California spread throughout the country. In 1971 there were 20,000 people in California prisons; by 2010 the population had increased to 162,000 people, of which 45 percent are estimated to be mentally ill. We in California now have an opportunity to lead again—this time to show that there is a better approach. We can begin a counter-revolution by setting a new standard for how we deal with people whose mental illness manifests through criminal activity. We will prove to the country that there is another, better approach—an approach that saves money and saves lives from being forsaken.

Mentally ill offenders receive longer sentences than non-mentally ill offenders across all felonies.



The population of mentally ill inmates in CA prisons has almost doubled since 2000.



The mentally ill who fill our prisons range from the violent to the nonviolent, and from those who were born with disabilities to those who have been damaged by circumstances and environment. According to a recent report from the National Sheriff's Association and Treatment Advocacy Center, ten times as many mentally ill people are in prison and jail in America today than are in mental health treatment facilities.[3]

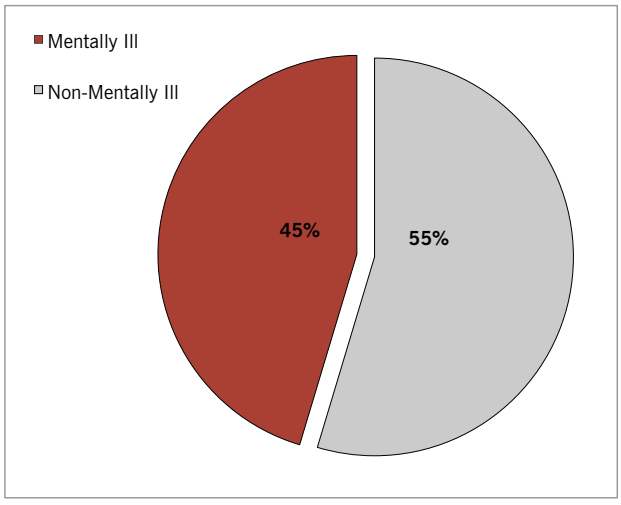
The problem is not only that many mentally ill people—left with no support and limited resources—tend to commit crimes (including those associated with homelessness and addiction). The problem is also that once they are in the system, they tend to be subjected to far harsher sentencing than others for the very same crimes. This may be born of a conscious sense that judges have that society is providing no meaningful "treatment" other than imprisonment. Or it may grow out of a subconscious animus or fear of those who are different in any way. Whatever the source, though, the effect is the same: despite rules of court in California designed to mitigate punishments for mentally ill offenders, the average sentence imposed on defendants suffering from mental illness is longer than the average sentence imposed on defendants who do not have mental health diagnosis but who committed the same crime. Unfortunately this is true across every category of crime in California. For example, the average sentence for burglary imposed on mentally ill defendants is 30 percent longer than the average sentence for non-mentally ill defendants convicted of the same crime.

The story grows darker still. When it comes time to be considered for release, once again the mentally ill fare miserably. For example, the number of mentally ill prisoners denied relief under new resentencing laws enacted under Proposition 36 is three times greater than the number of non-mentally-ill prisoners who have been denied relief.

And once those suffering from mental illness are released—having served longer sentences—the system delivers the ultimate knockout blow. We provide virtually no effective mental health facilities and programs to help released prisoners who are in desperate need of mental health treatment. This service deficit naturally results in higher recidivism rates and an ongoing sense of social isolation and abandonment. And the cycle then begins again with new arrests, new prosecutions, new lengthy sentences, new impediments to release, and eventual release into a system that provides nothing but an inevitable, tragic trajectory back into the criminal justice system. This cycle is as truly appalling as it is truly avoidable.

The cascade, which began so long ago, has created a new segregation—the segregation of the sick, the infirm and the helpless (many of whom are also people of color, almost all of whom are extremely poor). Not unlike other practices of segregation in our nation's history, this segregation is also hidden from the general public behind the walls of our prisons and jails. But this time it is not occurring in the form of slavery on individual farms and homes–today it is occuring behind the bars of prison cells.

Mentally ill inmates represent 45% of the total California prison population.



From time to time there have been efforts to expose this disaster but, until now, bold proposals for solutions have been lacking. We have seen periodic criticism, but no serious desire or determination for change. We, in California, can and will do better. Today, we jointly offer three modest but significant proposals to start us on the path of compassionate, fair and cost-effective solutions to the crisis we face:

1. **Reform the Way We Sentence the Mentally Ill:** We propose that all new sentences take into account the mental health of each defendant and, where appropriate, provide a non-prison sentence for any defendant charged with a nonviolent crime/ nonserious offense. This new sentencing would apply when the sentencing judge finds that the defense has shown by a preponderance of the evidence that the crime was likely committed as a result of the defendant's mental illness. Under such a circumstance, the defendant will be sentenced to mental health treatment and monitoring in a non-custodial setting. We propose to provide funding for mental health treatment for these defendants throughout the State. The cost of such treatment is significantly less than the cost of incarceration.

2. **Provide Meaningful Treatment in Prison**: We propose that when a sentencing judge finds (a) that a defendant's serious offense was caused in large part by his mental illness, or (b) that a defendant who committed a nonserious offense needs to be incarcerated due to the danger to himself or others, the judge will order the provision of meaningful mental health services as part of the terms and conditions of incarceration. These mental health services, although overseen and provided by the Bureau of Prisons, will nevertheless be reviewed from time to time by a special Mental Health Prison Oversight Court, which will be set up to assure that proper mental health services are being provided to each incarcerated defendant. This special court will be made up of judges and mental health professionals who will work together to

fashion and oversee the treatment of incarcerated prisoners in need of mental health services. This new Mental Health Prison Oversight Court will provide initial sentencing recommendations to trial court judges who request the court's input. Following a defendant's sentencing, the new court will have authority to oversee the mental health treatment of the incarcerated defendant, and will be empowered to order changes to the treatment plan that the court deems appropriate. This is a bold new proposal to integrate the independence of the prison system with the oversight of a special court as part of the judiciary. We recognize the problems and challenges of implementation, but we are confident that the goodwill and creative cooperation of all concerned will allow for the implementation of this change.

3. **Continue Meaningful Treatment After Prison**: Finally, we propose that all prisoners, prior to release, be evaluated for post-release mental health needs and, where appropriate, be referred to mental health centers for the ongoing provision of mental health care. These new mental health centers will be located throughout the state and will have access to the mental health records of the released prisoners, recommendations for appropriate post-release mental health care, and the funding needed to provide the recommended services for at least one year following release. As indicated above, providing these services will more than pay for itself in terms of costs saved by avoiding the extraordinary (financial and human) costs of incarceration.

We are proud that a new era marking the end of "sentencing for vengeance" and transforming the goal of being "tough on crime" with the goal of being "smart on crime" has begun to take hold. We are proud that the voters and policymakers are growing in their willingness to separate true criminals from those whose actions are not driven by aggression, violence or ill-intent. We are hopeful that the concept of vengeance is no longer being treated as the sole or primary focus of criminal sentencing, but is instead being treated as only one of several factors (including individual culpability and rehabilitation) that inform a just sentence. But amidst these positive changes, we must not ignore one of the great persistent injustices of modern criminal law: not only are poor people and people of color disproportionately imprisoned, but a dominant root cause of much criminal activity is mental illness. While the solution to that challenge of poverty or insidious discrimination is not easily in our grasp, we do have the readily available and affordable tools to help address the role that mental illness plays in criminality. Our report and modest proposals are an important first step towards that goal.

A note on methodology:
Unless otherwise specified in this report, all of the data reported herein was provided by the California Department of Corrections and Rehabilitation ("CDCR") and analyzed at Stanford Law School. The data reflects the California prison population as of March 5, 2014.

This report defines "mentally ill prisoner" as an inmate suffering from a serious mental illness, as diagnosed by the prison Mental Health Delivery System, within the past year. This definition best corresponds to the definition used by the United States Department of Justice in its national survey of mental health in prisons and jails referenced throughout this report.

A Brief History Of Deinstitutionalization In California

In the early 1950's California was the vanguard of a significant transformation of the nation's mental health system. This transformation resulted in a shift from a state-operated public mental health system to a decentralized system of care, accompanied by major changes in the funding relationship between state and local governments with regard to mental health services delivery. This transfer from state to local control, known as "deinstitutionalization," was accompanied by a sharp increase in California's state prison population—most notably, the population of mentally ill inmates.

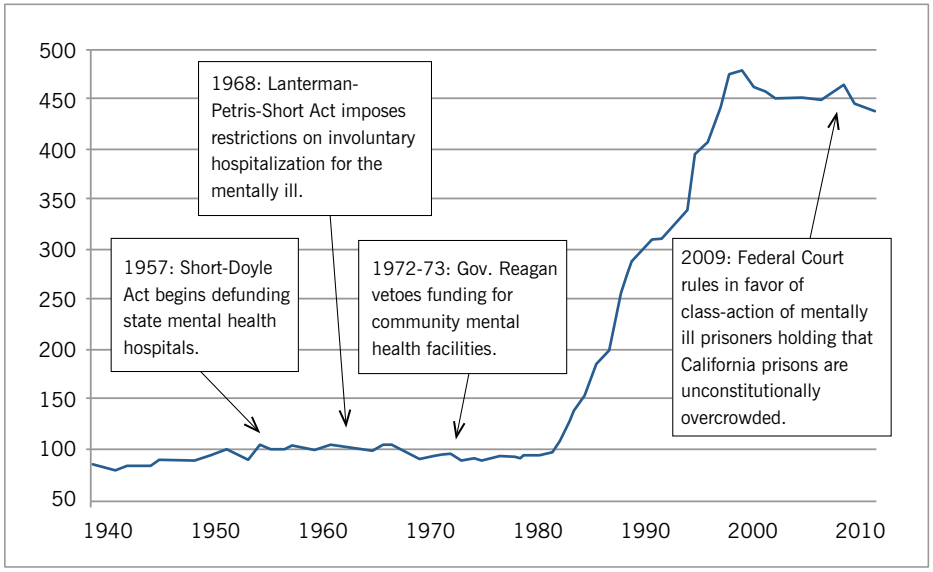
Prior to 1957, mental health services were delivered by a state operated and funded institutional system, which included fourteen hospitals. Eight of these hospitals served the mentally ill, four cared for the developmentally disabled, and two served both populations.

In 1957, the California legislature passed the Short-Doyle Act in response to the growing number of the mentally ill being confined in public hospitals. The Act, which provided state funds to local mental health service delivery programs, was developed to address concerns that some mentally ill individuals were better served by local, outpatient services rather than 24-hour hospital care. Lawmakers believed that local programs would allow the mentally ill to remain in their communities, maintain family ties, and enjoy greater autonomy. When first enacted, the Short-Doyle Act provided state funding for 50 percent of the cost to establish and develop locally administered and controlled community mental health programs.

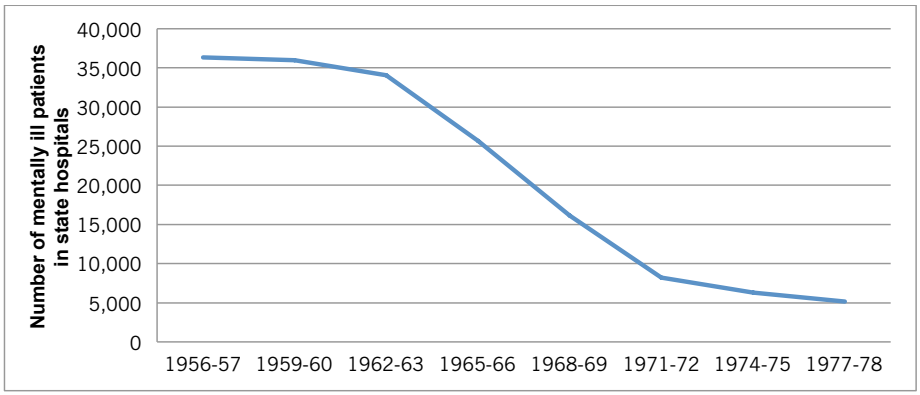
In 1968, the legislature passed the Lanterman-Petris-Short Act, which further reduced the population of state mental health hospitals by requiring a judicial hearing prior to any involuntary hospitalization. The Act also initiated increased financial incentives for local communities to take on the provision of mental health services.

As a result of this long-term transfer of state operation and oversight to a decentralized, community-based mental health care delivery model, the state mental hospital population declined from 36,319 in 1956 to

The incarceration rate in California skyrocketed when funding was pulled from its state mental hospitals.



Between 1967 and 1975, Governor Ronald Reagan slashed funding to mental hospitals leading to a dramatic decline in the number of mentally ill individuals being treated in the hospital setting.



Source: Legislative Analyst's Office, "Major Milestones: 43 Years of Care and Treatment of the Mentally Ill," (2000).

8,198 in 1971.[4] Three public mental hospitals closed during this time period. The legislature intended for the savings from these closures to be distributed to community programs. However, in 1972 and 1973 then-Governor Ronald Reagan vetoed the transfer of these funds. Between 1974 and 1984, the funding of community mental health programs was in constant flux, with many counties lamenting local mental health service gaps due to lack of sufficient funding.

The shift from state to local services was unexpectedly accompanied by a sharp increase in the population of the mentally ill within California's criminal justice system. In 1973, hearings were held by the California State Senate to discuss this concern. In 1980, a study published in the *American Journal of Orthopsychiatry* concluded that emptying the public mental health hospitals had "forced a large number of these deinstitutionalized patients into the criminal justice system."[5] Two other studies published in 1982 and 1983 by researchers at the University of Southern California indicated that the problem was only getting worse.[6]

Today, according to a recent survey of public mental health services issued jointly by the National Sheriffs' Association and Treatment Advocacy Center, "[in California] there are almost no public psychiatric beds available for individuals with serious mental illnesses."[7]

EXPERT ANALYSIS: The Tragic Case Of Mentally Ill Prisoners In California

Craig Haney

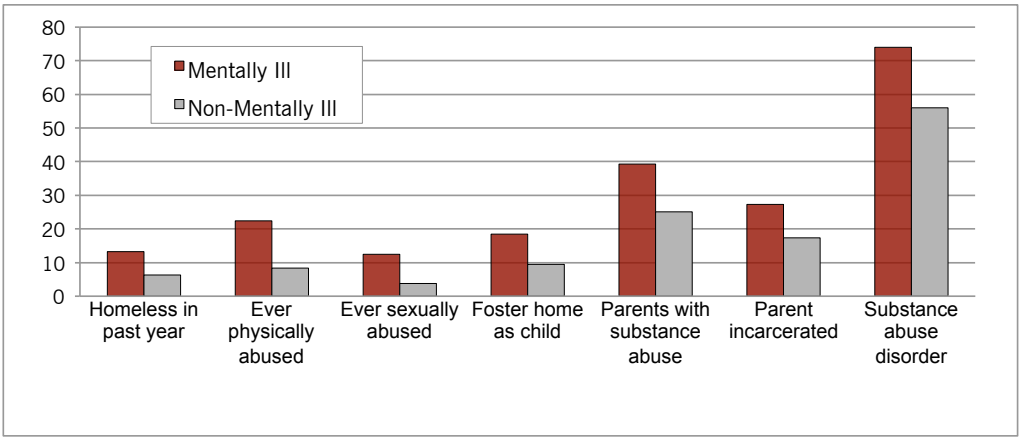
Treatment of the mentally ill in the United States is in a state of crisis. The mentally ill in this country are far more likely to be treated in jail or prison than in any healthcare facility. Presently, the United States incarcerates an estimated 350,000 prisoners who suffer from serious mental illness, almost 10 times the number of persons housed in the nation's psychiatric hospitals. In California alone, there are over 30,000 seriously mentally ill prisoners presently confined in state prison, as compared to fewer than 6,000 persons in state psychiatric hospitals, making CDCR the de facto mental health treatment provider in the state. Although litigation-related reforms have resulted in a significant overhaul of prison mental health services provided by the CDCR, mental health care in prison still falls well below minimal constitutional standards in many important respects.

Craig Haney, Distinguished Professor of Psychology, University of California, Santa Cruz. Photo courtesy of Loteria Films.

Prisons and jails are singularly ill-suited to house the mentally ill. Premised on punitive forms of social control, prisons are not remotely compatible with the kind of supportive therapeutic milieus that the mentally ill require. They are austere and intimidating environments that are painful and difficult for even the strongest and most resilient prisoners to withstand. The pains of imprisonment—severe material deprivations, highly restricted movement and liberty, lack of meaningful activity, a nearly total absence of personal privacy, high levels of interpersonal uncertainty, danger, and fear—are powerful psychological stressors that can adversely impact a prisoner's well-being.

Not surprisingly, these stressful conditions take a greater psychological toll on mentally ill prisoners. They are especially sensitive to the unique stresses and

Mentally ill individuals are much more likely to experience factors that contribute to an increased risk of committing crimes.



Source: United States Dept. of Justice, Bureau of Justice Statistics, "Mental Health Problems of Prison and Jail Inmates," (2006).

traumas of prison life, and their psychiatric conditions often deteriorate as a result. Their vulnerabilities place them at great risk to be victimized—for example, they are much more likely to be sexually assaulted than other prisoners. Some prisoners react to the extreme psychic stresses of imprisonment by taking their own lives. Tragically, rates of suicide inside prisons and jails are much higher among the mentally ill.

Behavioral problems that are associated with their psychiatric conditions also place the mentally ill at greater risk of committing rule violations, which typically result in the imposition of harsh disciplinary sanctions. Thus, largely because of their psychiatric illness, mentally ill prisoners are significantly more likely than other prisoners to be housed in punitive segregation units where they are subjected to solitary confinement and other severe deprivations. Extensive research has documented the range of adverse symptoms that have been consistently observed in prisoners in solitary confinement, including appetite and sleep disturbances, anxiety, panic, hopelessness, depression, rage, loss of control, paranoia, hallucinations, self-mutilations, and suicidal ideation. For those with a preexisting mental illness, psychiatric symptoms often worsen. Most punitive isolation units are operated in such a way that it is virtually impossible for mentally ill prisoners to receive adequate, effective treatment there.

Double cell with two inmate-patients, California Institute for Men, (2013). Photo courtesy of Loteria Films.

The CDCR has four levels of mental health treatment designation, ranging from long-term to emergency treatment.

Level of care	Description
Correctional Clinical Case Management System (CCCMS)	• Lowest level of mental health care • Treatment for "serious mental illness," according to certain DSM Axis I diagnoses (e.g. schizophrenia, psychotic disorder, bipolar disorder, major depressive disorder) • Prisoners stable with treatment • Treatment includes medication, individual and group therapy
Enhanced Outpatient Program (EOP)	• Segregated housing • Treatment for acute onset or significant decompensation with symptoms including delusional thinking, hallucinations, vegetative affect • Global Assessment Score less than 50 • Treatment includes medication, individual and group therapy, at least 10 hours per week of structured therapeutic activities
Mental Health Crisis Bed	• Inpatient psychiatric care, with 10-day maximum stay • Continuous therapeutic assistance to inmate-patients whose condition requires 24 hours or more to achieve stabilization • Danger to self or others • Global Assessment Score less than 30 • Treatment to control and alleviate symptoms with emergency medication if necessary
Inpatient at Dept. Mental Health Intermediate and Acute Care	• Acute exacerbation of a chronic major mental illness, marked impairment, and dysfunction in most areas (i.e. daily living activities, communication and social interaction) • Highly structured in-patient psychiatric care with 24-hour nursing supervision • Danger to self or others • May require neurological/neuropsychological consultation • Anticipated discharge within 30-45 days

At the other end of the spectrum—and particularly relevant in California—studies have shown that overcrowding greatly amplifies the stressfulness of prison life. Crowded conditions heighten the level of stress that persons experience by introducing social complexity, turnover, and interpersonal instability into an already dangerous prison world. Prison and jail settings are fraught with special dangers for vulnerable persons who cannot master the complex, and frequently violent, social dynamics of prison life.

Like most people incarcerated in prisons and jails throughout this

country, most mentally ill inmates will eventually be released back to the community. Because the state fails to provide many mentally ill prisoners with adequate mental health treatment, and subjects many of them to harsh forms of isolation, where their psychological conditions may have worsened, they confront special challenges when they are released back into free society. As a result, they are at greater risk to recidivate and return to prison. Yet, according to a recent study in *The Lancet*, the mentally ill are substantially less likely to commit a violent crime if taking appropriate psychiatric medication.[8]

These are very serious, complex, and long-standing problems that will require the implementation of a wide range of significant reforms in order to be solved. Although the vulnerabilities of mentally ill prisoners are manifested most clearly in prison, meaningful solutions must also come from beyond the prison walls. To be sure, it is critically important for the CDCR to continue to improve the quality of its mental health services to comply with constitutional mandates, and to end the practice of placing mentally ill prisoners in punitive isolation. But other critical criminal justice reforms are also necessary. These kinds of reforms require the development of a wide range of new programs: before, and in lieu of imprisonment; during imprisonment, for those mentally ill prisoners who cannot be diverted; and after imprisonment, as prisoners reintegrate into the community. They also require the training of key criminal justice personnel—attorneys, judges, correctional officers, and probation and parole officers—on the unique psychiatric needs of their clients. And they require the kind of sustained public and political attention, pressure, and resources necessary to bring them about.

The Promise Of Mental Health Courts In California

Mental health courts are a relatively recent phenomenon and one of many initiatives launched in the past two decades to address the large numbers of people with mental illness involved in the criminal justice system. There are currently approximately 40 mental health courts in 27 counties in California.[9] These courts should be expanded throughout the state to cover every defendant charged with a nonviolent offense as a result of mental illness.

A mental health court hearing in San Francisco Superior Court. Photo courtesy of Loteria Films.

A cost benefit analysis reported by Pew Charitable Trust and the MacArthur Foundation found that every $1 spent on one state's mental health court system resulted in $7 in incarceration savings.[10] In California, the annual prison cost for an inmate in the general population is $51,000, while the annual community housing and outpatient treatment costs for persons with mental illness is $20,412.[11]

In 2006, Santa Clara County estimated that its mental health court saved the state and county $20 million through reduced prison and jail sentences.[12] Sacramento County courts experienced an 88 percent decrease in the cost of serving mentally ill clients through its mental health court, as compared to serving those same clients in the traditional court system. Similar savings were realized in the mental health court operated in San Francisco County.[13] Recognition of these positive fiscal outcomes has led to the expansion of mental health courts in New York, Michigan, Washington and South Carolina.

In California, mental health courts are administered by county Superior Courts, which provide a separate docket for persons charged with nonviolent crimes who have been diagnosed with a mental illness. These courts involve collaboration between criminal justice and mental health professionals, and generally offer judicial supervision of required mental health treatment and other services in lieu of jail time.[14]

The social and public health benefits of mental health courts are also clear. The focus on early intervention allows offenders access to treatment prior to appearing before a mental health court. These offenders are more likely to stay in treatment than those whose cases are handled by a traditional court. Mental health court participants also demonstrate significant improvements in functioning and quality of life, reductions in psychological distress, and amelioration of drug and alcohol problems.[15] Studies also indicate that mental health courts reduce recidivism among mentally ill offenders. In Michigan, the State Administrative Corrections Office evaluated ten mental health courts and found that participants re-offended at a rate 300 percent lower than non-participants.[16]

Thus, the cost savings and public benefits that mental health courts provide through drastically reduced recidivism, early and less expensive intervention measures, and an overall reduction in crime demand their expansion in California.

LORENZO'S STORY

According to his mother, Lorenzo was a typical boy growing up in California. He enjoyed helping around the house and playing with his friends. But around the age of ten or eleven, Lorenzo's mother noticed a change in him. He stopped spending time with his friends and began spending more and more time alone.

His mother thought it might just be typical pre-adolescent changes until she came home one day and Lorenzo asked her, "Do you hear them? They're trying to get me!" Her first worry was that Lorenzo had begun to use drugs, so she immediately took him to the emergency room for an evaluation. That's when Lorenzo was diagnosed with schizophrenia.

Over the next two decades, Lorenzo's illness drove him to the streets where he committed petty thefts in order to survive. He spent a great deal of time in and out of jail for these offenses, but never got the treatment he needed for sustained improvement.

All of that changed when he became a participant in San Francisco's mental health court. There, working with a team of

Photo courtesy of Loteria Films.

mental health practitioners and court and law enforcement officials Lorenzo was given the resources and compassionate oversight he needed to address and manage the symptoms of his mental illness. He has been a model participant in the court and is now in school to become a medical technician.

Lorenzo's mother had been praying 26 years for some relief for Lorenzo from the cycle of mental illness, homelessness and incarceration. Now, she has her son back.

Mentally Ill Inmates And The Crisis Of Prison Overcrowding

In 2011, the United States Supreme Court issued its landmark opinion affirming a lower court decision that crowding in California's prisons had reached unconstitutional levels and ordering the state to reduce its prison population to 137.5 percent of design capacity.[17]

Prison dorm unit, which houses mentally ill prisoners, California Institute for Men (2013).

The percentage of prison inmates exhibiting symptoms of mental illness is exponentially higher than that of the non-inmate population.

	Mania Disorder Symptoms	Major Depressive Disorder Symptoms	Psychotic Disorder Symptoms
Percentage of all state prison inmates experiencing symptoms within the past 12 mos.	43.2%	23.5%	15.4%
Percentage of persons age 18 or older in U.S. population experiencing symptoms in past 12 mos.	1.8%	7.9%	3.1%

Source: United States Dept. of Justice, Bureau of Justice Statistics, "Mental Health Problems of Prison and Jail Inmates," (2006).

The case began two decades earlier, in 1990, with a class action suit brought in the United States District Court on behalf of mentally ill prisoners, who brought to light deplorable conditions and medical neglect within California's prisons, amounting to a deprivation of constitutional rights and a violation of the ban against cruel and unusual punishment. In 1995, following a 39-day trial, District Court Judge Lawrence Karlton found "overwhelming evidence of the systematic failure to deliver necessary care to mentally ill inmates" who, among other illnesses, "suffer from severe hallucinations, [and] decompensate into catatonic states." Judge Karlton appointed a special master to oversee implementation of a remedial plan. Yet the situation continued to deteriorate, according to periodic reports from the special master.

Late last year, a special three-judge panel overseeing the litigation ordered the state to meet the prison population cap set by the Supreme Court in 2011. At the request of Governor Jerry Brown, this February, the three-judge panel granted the state a two-year extension to comply with the prison population reduction plan. In granting the extension request, the panel of judges required the state to implement certain immediate measures, such as expanding reentry support programs, providing additional "good time" credits to certain inmates, and implementing new parole rules, including developing a new parole process based on Proposition 36 for some nonviolent "second strike" inmates.

Mentally ill inmates experience significantly higher rates of prison discipline, and are twice as likely to be injured in a prison fight than non-mentally ill inmates.

	Prisoners with Mental Illness	Prisoners without Mental Illness
Charged with prison rule violation	57.7%	43.2%
Injured in a prison fight	20.4%	10.1%

Source: United States Dept. of Justice, Bureau of Justice Statistics, "Mental Health Problems of Prison and Jail Inmates," (2006).

This April, Judge Karlton revisited the treatment of mentally ill prisoners and in a 75-page opinion found that the state's supervision and disciplinary procedures for mentally ill prisoners remains unconstitutional. Judge Karlton determined that the state prison system had still not adequately addressed the issues raised in his 1995 opinion and that the prison system continues to use punitive measures, including solitary confinement, to control symptoms of mental illness. Judge Karlton denied the state's request to end federal oversight of the treatment of mentally ill prisoners in California, ordered new remediation measures, and directed the special master to report on the state's progress within six months.

The Mistreatment Of Mentally Ill Prisoners Under "Three Strikes"

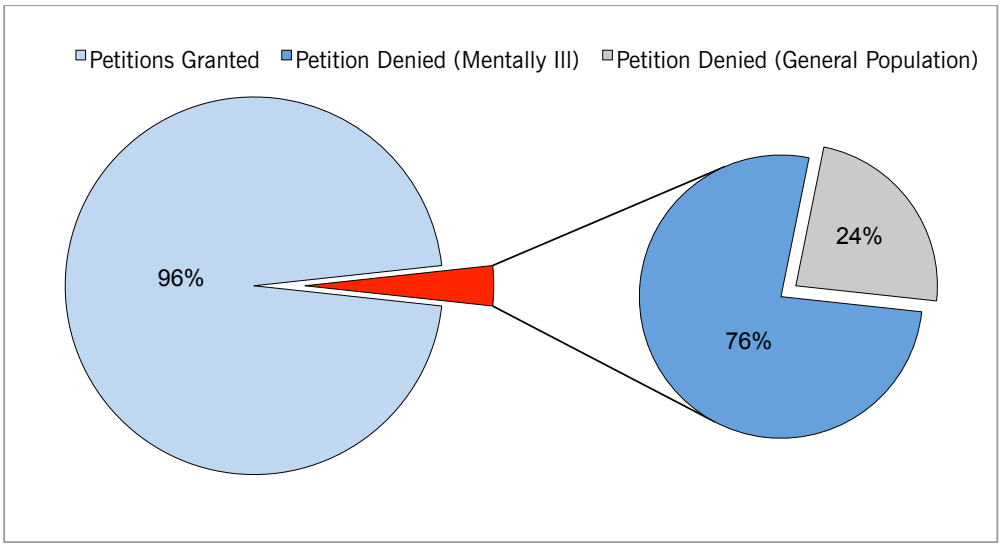
A disproportionate number of inmates sentenced to life in prison under California's "Three Strikes" sentencing law are mentally ill. Prisoners sentenced under the Three Strikes law are roughly twice as likely to be mentally ill as other California prisoners. California law needs to be clarified by courts and the legislature, if necessary, to ensure that a defendant's illness is not used to justify longer imprisonment in any context. The problem is particularly acute in the Three Strikes context.

In some ways it is not surprising that a disproportionate number of Three Strikes prisoners are mentally ill. Compared to defendants without mental health problems, mentally ill defendants have a higher rate of homelessness and drug addiction, often have difficulty contributing to their own defense, and, as discussed elsewhere in this report, generally receive longer sentences than other defendants for the same crimes. The lack of public mental health treatment resources contributes to recidivism by the mentally ill, who eventually become subject to life sentences under the Three Strikes law. Improved public mental health services, particularly residential treatment programs for released prisoners reentering the community, will help address this problem.

In 2012, 70 percent of California voters enacted Proposition 36 to provide an opportunity for inmates sentenced to life under the Three Strikes law for non-serious, non-violent crimes to petition for early release. To date, over 1,700 prisoners have been re-sentenced and released from prison under Proposition 36. The recidivism rate of prisoners released under Proposition 36 has been astonishingly low (less than 1.5 percent). However, mentally ill prisoners sentenced under the Three Strikes law are not receiving the same benefit from the reforms to California's Three Strikes law.

Under Proposition 36, a prisoner sentenced to life for a non-serious, nonviolent crime will receive a reduced sentence unless a Superior Court judge determines that re-sentencing the prisoner would endanger public safety.[18] According to CDCR data, a large majority (95 percent) of eligible prisoners who petition for re-sentencing under Proposition 36 has received a shorter

Mentally ill prisoners are disproportionately denied shorter sentences under Proposition 36.



sentence. Yet, 75 percent of those prisoners who have been denied a shorter sentence under Proposition 36 are mentally ill.

One of the reasons that mentally ill Three Strikes prisoners are faring poorly under Proposition 36 has to do with prison disciplinary rules, which play a large role in a judge's determination of future risk to public safety. Mentally ill prisoners generally have more prison violations than inmates without mental health problems. While this is not surprising, it is problematic. According to the findings of the federal district court and the special master overseeing the prison disciplinary procedures in *Coleman v. Brown*, since 1995 prison officials have been using disciplinary violations and punishment to control the behavior of the mentally ill in lieu of treatment. As a result, the Coleman court has ruled that prison disciplinary procedures involving mentally ill inmates over the past 20 years have been in violation of constitutional protections and has ordered remedial action.

Superior Court judges evaluating the prison disciplinary records of mentally ill inmates petitioning for new sentences under Prop. 36 should be aware of the historic problems with the prison disciplinary rules involving mentally ill inmates and take into account the prison's failure to adequately treat and discipline mentally ill prisoners when making a dangerousness evaluation under Proposition 36.

Furthermore, California law generally needs to be clarified to ensure that judges do not impose longer sentences on defendants just because they are mentally ill. Regulations governing which prisoners should be released on parole specifically provide that a prisoner's mental health status may indicate increased public safety risk and justification for denial of parole.[19] This provision should be eliminated and brought into line with California Rules of Court governing criminal sentencing proceedings, which provide that an offender's mental illness is a mitigating factor that reduces the offender's criminal culpability and justifies a *reduced* sentence.[20] The United States Supreme Court has repeatedly held that defendants whose mental illness contributed to their crimes should not receive the same punishment as defendants who do not have mental health problems. In *Penry v. Lynaugh*, 492 U.S. 302 (1989) the Court explained:

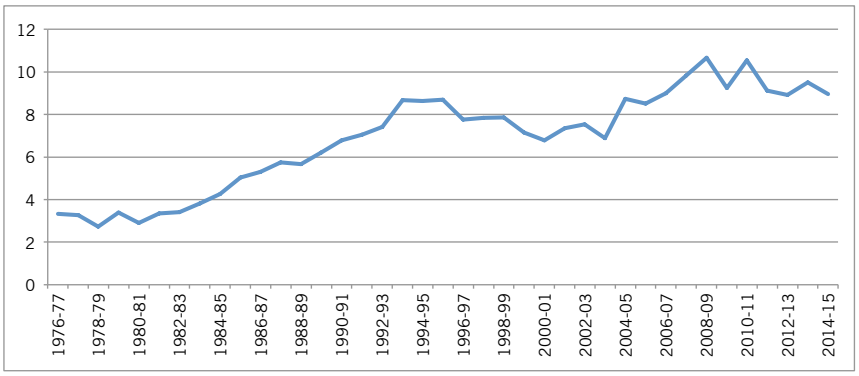
[We affirm] the belief, long held by this society, that defendants who commit criminal acts that are attributable...to emotional and mental problems may be less culpable than defendants who have no such excuse.

This principle has been extended to limited criminal contexts, like the death penalty. The same rules should be applied to the vast majority of defendants in California and nationwide who do not face capital punishment and who may have committed their crimes as result of mental illness.

Investment In Community Mental Health

The community mental health system has been deficient for many years. We have recently made efforts to rebuild the system—which provides necessary services and programs for collaborative mental health courts, the Department of Corrections, and law enforcement to divert mentally ill offenders to mental health treatment instead of jail or prison—but progress has been slow.

The percent of California's state budget dedicated to prisons has doubled since 1976



Source: California Department of Finance, California Budget Project, (2014).

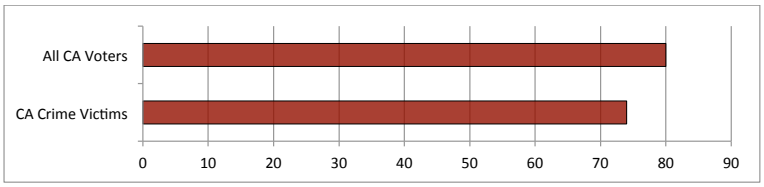
In California, county governments now largely bear the responsibility for funding and providing the majority of mental health programs, including treatment services for low-income, uninsured individuals with severe mental illness and programs associated with the Mental Health Services Act of 2004 ("MHSA," also known as Proposition 63).

Passed in November 2004, Proposition 63 imposed a one percent income tax on personal income in excess of $1 million. Proposition 63 expanded mental health services for children and adults with severe mental illness whose needs were not covered by existing insurance programs or other federally sponsored programs. Proposition 63 provides funds to counties to expand and develop innovative programs for the mentally ill.

This year, over $1 billion will be allocated to county mental health programs and approximately $80 million will be allocated to state mental health programs under Proposition 63. In Los Angeles alone, programs funded by Proposition 63 provided services to over 150,000 people last year. Participants in the Full Service Partnership program funded by Proposition 63 experienced a reduction in homelessness, psychiatric hospitalization and incarcerations:

- Mentally ill adults achieved a 71% reduction in the number of days spent homeless.
- Mentally ill adults achieved a 50% reduction in the number of days spent in jail.
- Mentally ill youth achieved a 59% reduction in days spent in Juvenile Hall and a 40% reduction in the number of days psychiatrically hospitalized.

California voters overwhelmingly support the expansion of mental health services.



Source: Californians For Safety and Justice, (2013).

Building on this success, Senator Steinberg helped to pass SB 82, the Mental Health Wellness Act of 2013, which provided funds to increase local capacity to assist mentally ill individuals in crisis. SB 82 funds mobile crisis teams, crisis stabilization beds, and better triage for mentally ill individuals. This April, the state approved $75.3 million in

grants, adding 827 residential and crisis stabilization beds, and 39 vehicles and 60 staff for mobile support teams statewide.

In addition to these new state funding streams, the federal Affordable Care Act of 2012 expands eligibility criteria of Medi-Cal to include many mentally ill individuals in the criminal justice system. The Affordable Care Act also provides for a large expansion of mental health and substance use disorder coverage.

These programs have proven that increased support and services to indigent mentally ill individuals can help treat serious and debilitating conditions, help improve public safety (by reducing crime committed by untreated mentally ill individuals), and save money by diverting them from expensive and inappropriate placement in emergency rooms and jails. The state and counties should expand on the success of these programs that are benefits to us all.

A Plan To Stop Imprisoning And Start Treating Our Mentally Ill Citizens

From time to time there have been efforts to expose this disaster but bold proposals for solutions have been lacking. We have seen periodic criticism, but no serious desire or determination for change. We, in California, can and will do better. Recognizing the fundamental importance of a compassionate, just, safe and cost-effective solution, the legislature can take the following immediate steps to address the crisis of mental illness in California's justice system. Each of these proposals support priorities set forth earlier in the Introduction of this Report: (1) Trial courts should take into account the mental health of each defendant at sentencing; (2) Once sentenced, the Department of Corrections and a newly established court, working together, should oversee the mental health treatment of each prisoner; and (3) All prisoners must have a reentry plan that provides for continued mental health treatment upon release from prison.

These recommendations build on one another in order to achieve truly robust and comprehensive reform. Our plan to stop imprisoning and start treating mentally ill citizens consists of three modest but significant proposals:

1. **Reform the Way We Sentence the Mentally Ill:**

Mental Health Court in San Francisco. Photo courtesy of Loteria Films.

We propose that all new sentences take into account the mental health of each defendant and, where appropriate, provide a non-prison sentence for any defendant charged with a nonviolent crime/non-serious offense. This new sentencing would apply when the sentencing judge finds that the defense has shown by a preponderance of the evidence that the crime was likely committed as a result of the defendant's mental illness. Under such a circumstance, the defendant will be sentenced to mental health treatment and monitoring in a non-custodial setting. We propose to provide funding for mental health treatment for these defendants throughout the state. The cost of such treatment is significantly less than the cost of incarceration.

Trial Courts Should Take Into Account the Mental Health of Each Defendant at Sentencing. For many reasons the mentally ill are disproportionately involved in the criminal justice system. We must increase diversion programs to redirect mentally ill defendants away from prisons and jails—which exacerbate mental illnesses, impede treatment, and undermine public safety—toward proven mental health treatment services.

We urge the immediate enactment of SB 1054 and the Mentally Ill Offender Crime Reduction Grant (MIOCR) Program. SB 1054 allocates $50 million from the Recidivism Reduction Fund to fund a competitive grant program for mental health courts and other programs throughout California, helping divert people with mental illness out of corrections and into services. The MIOCR grant program has been successful in the past in reducing the number of people with mental illness in jail and should be reestablished.

2. Provide Meaningful Treatment in Prison:

We propose that when a sentencing judge finds (a) that a defendant's serious offense was caused in large part by his mental illness, or (b) that a defendant who committed a nonserious offense needs to be incarcerated due to the danger to himself or others, the judge will order the provision of meaningful mental health services as part of the terms and conditions of incarceration. These mental health services, although overseen and provided by the Bureau of Prisons, will nevertheless be reviewed from time to time by a special Mental Health Prison Oversight Court, which will be set up to assure that proper mental health services are being provided to each incarcerated defendant. This special court will be made up of judges and mental health professionals who will work together to fashion and oversee the treatment of incarcerated prisoners in need of mental health treatment. This new Mental Health Prison Oversight Court will provide initial sentencing recommendations to trial court judges who request the court's input. Following a defendant's sentencing, the new court will have authority to oversee the mental health treatment of the incarcerated defendant, and will be empowered to order changes to the treatment plan that the court deems appropriate. This is a bold new proposal to integrate the independence of the prison system with the oversight of a special court as part of the judiciary. We recognize the problems and challenges of implementation, but we are confident that the goodwill and creative cooperation of all concerned will allow for the implementation of this change.

Call to Action!

Call Governor Brown and tell him to support the needs of people with mental illness. We need to treat mental illness—not criminalize it.

Tell Governor Brown to support these common sense reforms:

- Expand mental health courts statewide
- Provide mental health case managers for mentally ill parolees
- Support transitional housing for mentally ill inmates leaving prison
- Continue to provide services to Three Strikes prisoners released under Prop. 36

Call the Governor's Office at (916) 445-2841 or email him by visiting Gov.CA.Gov.

Once Sentenced, CDCR and a Newly Established Court Will Oversee the Treatment and Housing of Each Mentally Ill Prisoner. Despite two decades of federal litigation designed to improve the mental health care of California prisoners, treatment for the mentally ill in prison still falls well below minimal constitutional standards in many important respects.

We must provide the mentally ill with appropriate housing and personnel to treat their needs.

We urge expanded training for corrections officers, and mental health, healthcare, and rehabilitative programing staff. Establish an intensive training program for correctional officers, healthcare, mental health, and rehabilitative program staff. Require in-service training that integrates mental health, healthcare, and correctional officer staff.

We urge the construction of mental health treatment facilities and substance abuse treatment facilities. The Governor's Budget proposes an additional $500 million on top of the $1.2 billion already budgeted for jail construction. This funding needs to be expanded to include construction of mental health treatment facilities and substance abuse treatment facilities.

3. Continue Meaningful Treatment After Prison:

Finally, we propose that all prisoners, prior to release, be evaluated for post-release mental health needs and, where appropriate, be referred to mental health centers for the ongoing provision of mental health care. These new mental health centers will be located throughout the state and will have access to the mental health records of the released prisoners, recommendations for appropriate post-release mental health care, and the funding needed to provide these services for at least one year following release. As indicated above, providing these services will more than pay for itself in terms of costs saved by avoiding the extraordinary (financial and human) costs of incarceration.

Prisoners Will Be Provided with a Mental Health Reentry Plan Upon Release. The mentally ill confront distinct, yet treatable, challenges as they reintegrate into the community. We must provide them with support as they meet these challenges.

We urge the guarantee of transitional housing upon release for the mentally ill. Require all mentally ill parolees to be released 90 days early into an intensive transitional housing program.

We urge the creation of a corps of mental health parole officers. Create a specialized caseload for parole agents for mentally ill parolees with a caseload of 1 parole agent to 20 mentally ill parolees. The mental health parole agent should have a minimum of an Associate's Degree, at least one year of social casework experience, and training in cognitive behavior treatment and motivational interviewing.

We urge the re-establishment of Parole Out-patient Clinics (POC) as case management offices. As the parole population decreases, the state should change the mission of the Parole Out-Patient Clinic and establish three different levels of case management:

- **Initial 30 Day Case Manager**: This case manager will meet with the parolee immediately upon release, assess for needs, and establish initial essential services, including housing, sobriety maintenance, and medical and mental health care.
- **Long-term Case Manager**: This case manager will partner with multiple parole agents to assist both the parolee and the parole agent in maintaining access to services.
- **Mental Health Case Manager**: A specially trained social worker who will work with parolees identified as mentally ill and their specially-trained parole agents to develop individualized case management plans, ensure the parolee is enrolled in Medi-Cal, connect the parolee with physicians, and establish the first medical and mental health appointments for the parolee. The parole agent and the case manager will work together to address all reentry needs of the parolee, including housing, health care and employment.

We urge that mentally ill Proposition 36 offenders receive state services. A disproportionate number of prisoners sentenced to life under California's Three Strikes law are mentally ill. We should continue to provide parolee services for prisoners released under Proposition 36. Last year, CDCR and Administrative Office of the Courts established a referral process for Proposition 36 offenders to receive existing parole reentry services. These services have helped ensure a historically low recidivism rate among prisoners released under Proposition 36 and should be continued.

Footnotes

1 Unless otherwise noted, all data in this report were provided by the California Department of Corrections and Rehabilitation (2014). For purposes of this report, "mental illness" is defined as a condition that qualifies for placement in the prison's Mental Health Delivery System within the last year.

2 Los Angeles Times, "Sheriff says proposed mental health cuts would burden L.A. jails," (May 25, 2010).

3 National Sheriffs' Association and Treatment Advocacy Center, "The Treatment of Persons with Mental Illness in Prisons and Jails." (2014).

4 Legislative Analyst's Office, *Major Milestones: 43 Years of Care and Treatment of The Mentally Ill* (2000).

5 G.E. Witmer, *From Hospitals to Jails: The Fate of California's Deinstitutionalized Mentally Ill*, *American Journal of Orthopsychiatry* 1980; 50:65-75.

6 See H.R.Lamb and R.W. Grant, *The Mentally Ill in an Urban County Jail*, Archives of General Psychiatry 1982; 39:17-22; H.R. Lamb and R.W. Grant, *Mentally Ill Women in a County Jail*, Archives of General Psychiatry 1983; 40:363-68.

7 National Sheriffs' Association and Treatment Advocacy Center, "The Treatment of Persons with Mental Illness in Prisons and Jails," (2014).

8 "Medications cut violence among mentally ill in study," *Wall Street Journal* (May 7, 2014).

9 Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report, Administrative Office of the Courts, Judicial Council of California (April 2011).

10 States' Use of Cost-Benefit Analysis: Improving Results for Taxpayers, Pew-Macarthur Results First Initiative (July 2013).

11 Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report, Administrative Office of the Courts, Judicial Council of California (April 2011).

12 *Id*.

13 Arley Lindberg, "Costs and Benefits of Behavioral Health Court: Findings from Examining Program Costs and Outcomes of San Francisco's Behavioral Health Court," (2009).

14 *Id*.

15 Fact Sheet: Mental Health Courts, Administrative Office of the Courts, Judicial Council of California, (April 2008).

16 "Mental health courts expand to treat offenders," *Grand Rapids Business Journal*, (March 12, 2014).

17 *Brown v. Plata*, 131 S. Ct. 1910 (2011).

18 *See* Cal. Penal Code Sec. 1170.126.

19 *See* Title 15 Sec. 2281(c)(5).

20 *See* Cal. Rule of Court Sec. 4.423(b)(2).